



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: Summit Rehabilitation Centers 2420 E Randol Mill Rd. Arlington TX 76011	MDR Tracking No.: M5-06-2064-01
	Previous Tracking M5-05-1211-01 #:
	Claim No.:
Respondent's Name and Address: Zurich American Insurance Company, Box 19	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "... Provider sent a request for reconsideration. Proof that carrier received request is also included. Carrier chose not to respond within the 28 day time frame rule..."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Although these peer reviews were performed in December 2003, the claimant's medical condition did not change and they continued to be applicable to the treatment being reviewed. All fees were paid according to the applicable guidelines, or they were not reasonable and necessary to relieve the effects of the compensable injury."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. EOB's

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
5-11-04 – 5-19-04	97110 (\$36.99 X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$443.88
5-11-04 – 5-19-04	97140 (\$34.13 X 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$102.39
5-26-04	97750-FC (\$37.05 X 12 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$444.60

5-11-04 – 6-15-04	95831, 96004, 97035, 99213, G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$990.87

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

In an e-mail dated 11-15-06, DOS 7-27-04 was withdrawn by the Requestor and will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did prevail on the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$990.87.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
 28 Texas Administrative Code Sec. 134.1, 134.202, 134.304, 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Respondent must refund the amount of the IRO fee (\$460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to reimbursement in the amount of \$990.87. The Division hereby **ORDERS** the Respondent to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision and Order by:

Medical Dispute

11-22-06

Officer

Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

INDEPENDENT REVIEW INCORPORATED

February 9, 2005 **AMENDED November 21, 2006 (formerly M5 05 1211 01)**

Re: MDR #: M5 06 2064 01 Injured Employee: ___
 DWC #: _____ DOI: ___
 IRO Cert. #: 5055 SS#: ___

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention: _____
Medical Dispute Resolution
Fax: (512) 804-4868

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a chiropractor who is currently listed on the DWC Approved Doctor List.

This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

Sincerely,

Jeff Cunningham, DC
Office Manager