



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Texas Imaging and Diagnostic Center 3840 W. NW Hwy, Ste 400 Dallas, TX 75220	MDR Tracking No.: M5-07-0027-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Requestor states "The referring physician has provided our office with clinical and a letter of medical necessity on this patient. Doctor felt the procedures to be medically necessary due to the patient's ongoing symptoms from his on the job injury of ___."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The position statement submitted by Texas Mutual does not address the disputed services.

Principle Documentation:

1. Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12/29/05	72148-WP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$757.60

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.

The Division has reviewed the enclosed IRO decision and determined that the Requestor **did prevail** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION FINDINGS AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is entitled to reimbursement in the amount of \$757.60.

In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Order by:

Medical Dispute Officer

11/15/06

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.

Clear Resolutions Inc.

An Independent Review Organization

3616 Far West Blvd. Suite 337-117

Austin, TX 7831

Amended November 15, 2006

October 27, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee _____

TDI-DWC _____

MDR Tracking #: _____

IRO #: _____

M5-07-0027-01

5327

Clear Resolutions, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to Clear Resolutions for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

Clear Resolutions has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The Reviewer is on the DWC Approved Doctor List (ADL). The Clear Resolutions Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including but not limited to:

- 2-page SOAP notes dated 12-22-05, 12-21-05, 12-19-05, 12-16-05, 12-13-05
- 3-pages SOAP notes dated 12-12-05
- 1-page Collections letter dated 8-24-06 from Texas Imaging & Diagnostic Center for lumbar MRI
- 2-pages lumbar MRI dated 12-29-05
- 1-page letter dated 2-1-06 from Guadalupe Rehab and Pain Center regarding MRI

CLINICAL HISTORY

The Patient was involved in an occupational injury on _____. The Patient was carrying a piece of metal when he slipped on the wet floor and landed on his back. He sought treatment at Guadalupe Rehabilitation & Pain Center. Initial examination revealed multiple positive examination findings; therefore, the Patient was referred for an MRI of the lumbar spine.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of MRI spinal for the date 12/29/05.

DETERMINATION / DECISION

The Reviewer disagrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services (72148-MRI Spinal) were medically necessary. Supporting documentation for the MRI was decreased motor strength, multiple positive orthopedic examination findings, and decreased sensory findings on the right S1 dermatomes. The examination findings correlated with the

positive MRI findings. Clinical evidence would support advanced diagnostic imaging to completely evaluate and rule-out disc pathology. MRI of the lumbar spine is supported with the medical documentation reviewed.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

Clear Resolutions has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Clear Resolutions has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Clear Resolutions Inc., I certify that there is no known conflict between the Reviewer, Clear Resolutions and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Clear Resolutions is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,
Clear Resolutions Inc.



Chris Crow
President & Chief Resolutions Officer

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

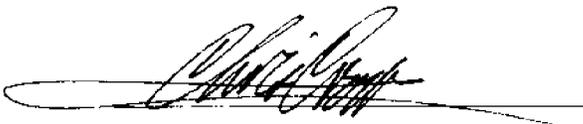
If you are disputing the decision, the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 27th day of October, 2006.

Name and Signature of Clear Resolutions Inc. Representative:

Sincerely,
Clear Resolutions Inc.



Chris Crow
President & Chief Resolutions Officer