



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

PART I: GENERAL INFORMATION

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

Requestor's Name and Address:

James Tanner, D. C.
5350 Staples Ste. 210
Corpus Christi, Texas 78411

MDR Tracking No.: M5-07-0079-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

LUMBERMENS UNDERWRITING ALLIAN, Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary (Table of Disputed Services) states, "Treatment was Med. Necessary."

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, "The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary."

Principle Documentation:

1. DWC-60/Table of Disputed Service

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-20-05	97750-FC (16 units at \$38.25)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$612.00
	Total Due		\$612.00

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. Per Rule 134.202(c)(1) the amount due the Requestor for the items denied for medical necessity is \$612.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 carrier 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 additional reimbursement in the amount of \$612.00. 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.

Findings and Decision and Order by:

Medical Dispute Officer

11-13-06

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.



Specialty Independent Review Organization, Inc.

November 7, 2006

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: ____

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

Ms. ___ was injured on ___ while employed with ____ . The treating doctor according to the records is Brian Randall, DC who apparently requested this functional evaluation. The patient injured herself when she fell in a child's vomit while carrying a baby at work. She has had three surgeries at this point with the third surgery in June of 2005. She has been performing postoperative rehabilitation prior to the FCE testing. She measures 5'2" and weighs 115 lbs. Her ROM was decreased with pain. Her objective testing via Oswestry indicates a severe self-perceived disability. Her lifting, endurance and non-material handling abilities were tested. Her testing revealed a medium PDL.

RECORDS REVIEWED

Records were received and reviewed from the requestor and from the respondent. Records from the requestor include: functional testing of 9/20/05, patient consult of 9/20/05, 6/16/05 through 9/8/05 notes from R. Francis, MD, operative report of unknown date by M. McDonnell, MD, DD report of 10/12/06 by J Rose, MD, 10/12/06 report by Sedgwick CMS, recon request of 6/1/06 and 8/14/06 and HICFA 1500.

Records from the respondent include the following (in addition to any previously mentioned records): 10/19/06 letter from Patricia Blackshear, 10/4/06 letter from S. Robinson, DWC 60 report with attachments and 1/25/05 peer review by Casey Cochran, DO.

DISPUTED SERVICES

The disputed service is a physical performance test/FCE (97750-FC) on 9/20/05.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer notes Dr. Cochran's opinion in January of 2005 that "an FCE could be accomplished in an attempt to determine her work ability." This is found in the second to last paragraph in his report. Secondly, Dr. Francis requests an FCE to determine the patient's progress with treatments. An FCE is a medically accepted part of the rehabilitation protocol and leads to determining if the treatment protocols are leading to improvement of the patient's functional abilities allowing a patient to return to work.

REFERENCES

Reed, P Medical Disability Advisor, Reed Group, 2005, Version 4.21

Saunders, R Industrial Rehabilitation-Techniques for Success, Saunders Group, 1995

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider 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 IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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 (other than a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with TDI/DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the DWC via facsimile, U.S. Postal Service or both on this 7th day of November 2006

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli