



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

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

Requestors Name and Address:	MDR Tracking No.: M5-07-0190-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: NORTH FOREST ISD, Box 29	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states (Table of Disputed Services), "Treatment provided to ...is reasonable and necessary per Texas Labor Code 408.21."

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

No response was received from the Respondent.

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)
10-11-05 – 12-02-05	97545-WH-CA (\$128.00 x 29 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,712.00
10-11-05 – 12-02-05	97546-WH-CA (\$64.00 x 6 units x 29 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$11,136.00
	Total Due		\$14,848.00

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.

Dates of service 9-20-05 – 10-10-05 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

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(5)(c)(i-ii) the amount due the Requestor for the items denied for medical necessity is \$14,848.00.

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 \$14,848.00. 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 by:

Medical Dispute Officer

12-06-06

Order by:

Amy Rich, Director,
Medical Dispute Resolution

12-06-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

November 28, 2006

Medical Review Division Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M5-07-0190-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse

determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The patient was working as a cook on ___ when she slipped on a wet floor, twisted and fell onto her left knee. After limited results were obtained following 2-weeks of medical management that included medication and physical therapy, an MRI was performed that revealed meniscal tears. The patient underwent arthroscopic repair followed by postoperative rehabilitation.

Requested Service(s)

Work Hardening (97545-WH), Work Hardening each additional hour (97546-WH) provided from 10/11/05 to 12/02/05.

Decision

It is determined that the work Hardening (97545-WH), Work Hardening each additional hour (97546-WH) provided from 10/11/05 to 12/02/05 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

On 01/18/05, an independent peer reviewer strongly stated that the disputed treatment in this case met statutory requirements for medical necessity. In addition, the patient's positive response was the basis for the reviewer's opinion that 2 additional weeks of treatment was medically necessary.

On 03/31/06, an IRO reviewer stated, "Subsequent to that surgery, the records also documented that the patient sustained functional deficits related to the injury, and that these deficits were being successfully addressed in all measured areas with a work hardening program. With documentation of improvement in the patient's condition and restoration of function, continued treatment is reasonable and necessary to effect additional gains. Therefore, since the patient still had documented functional deficits, and since the preceding 6-week utilization of this service fulfilled the statutory requirements¹ for medical necessity (the patient obtained relief, promotion of recovery was accomplished), it is reasonable to assume that this claimant will continue to improve for an additional 2 weeks."

This reviewer concurs with the professional opinions of both of those reviewers since the medical records, clearly, completely and fully document the disputed treatment fulfilled statutory requirements for medical necessity,

This decision by the IRO is deemed to be a DWC decision and order.

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.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

¹ Texas Labor Code 408.021

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M5-07-0190-01

Information Submitted by Requestor:

- Letter to IRO doctor from Dr. Gutierrez
- Description of claims from Dr. Gutierrez
- Letters of complaint from Dr. Gutierrez to TDI-DWC and Texas Department of Insurance
- Conversation log
- Notice of Determination
- Letter of determination
- Letter regarding reconsideration
- Request for Medical Dispute Resolution
- Appeal of Unreasonable Adverse Determination of Preauthorization Request
- Guideline(s) and References that support Multi-disciplinary Intervention such as Work Hardening
- Report on Legislative Recommendations From The Texas Workers' Compensation Commission To The 79th Texas Legislature December 2004.
- TWCC Fast Facts
- Work Hardening and Work Conditioning Programs Exempted from Preauthorization and Concurrent Review
- Articles describing: Functional Capacity Evaluations, Return to Work Rehabilitation Programs, Work Conditioning/General Occupational Rehabilitation Program, Work Hardening/Comprehensive Rehabilitation Program, and Outpatient Medical Rehabilitation Program (as defined by CARF)
- Medical Fee Guideline 1996
- Guidelines for Programs for Injured Workers
- Article from Mayo Clinic "Returning to work after an injury: Rehabilitation services can help"
- ODG Integrated Treatment/Disability Duration Guidelines
- Occupational Medicine Practice Guidelines
- Article "Pain, Suffering, and the Restoration of Function
- Assessment for Work Hardening, Individual Treatment Plan & Functional Goals and Objectives
- Report f Functional Capacity Evaluations
- Orthopedic Evaluations
- Physical Therapy Notes
- Initial Evaluation by Dr. Galvan
- Office notes by Dr. Galvan
- History and Physical evaluation by Dr. Freeman
- Report of Medical Evaluation by Dr. Machado
- Impairment Rating Report
- Operative Reports
- Orthopedic Report by Dr. Donovan
- Office Progress notes by Dr. Donovan
- Letters of Medical Necessity by Dr. Donovan
- One page of an orthopedic consult by an unknown doctor
- Work Hardening Assessment Psychosocial History
- Weekly Work Hardening Reports
- Table of Disputed Services
- EOBs

Information Submitted by Respondent:

None