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: ( ) Health Care Provider (X) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M5-07-0196-01 (current MDR #) M4-06-4181-01 (former MDR #)
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 01	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: The Requestor did not submit a position summary to MDR.
Principle Documentation:

1. DWC 60
2. Invoices for services in dispute

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: No position summary was submitted to MDR by the Respondent.
Principle Documentation: The Respondent did not respond to MDR.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-15-05	Shipping	☐ Yes ☒ No	$0.00
12-15-05	Braun power doors, exhaust modification, remote control, Non-skid floor and E-Z lock tie down	☒ Yes ☐ No	See note below regarding reimbursement of the services found to be medically necessary by the IRO reviewer
	Note: Per Rule 134.202(c)(6) "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies…"		

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 **majority** of the medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(6)
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 per Rule 134.202(c)(6). The Division hereby **ORDERS** the Respondent to remit this amount due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Order by:

		01-30-07
Authorized Signature	Typed Name	Date of Findings and 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.

December 26, 2006

ATTN: **Program Administrator**
Texas Department of Insurance/Workers Compensation Division
7551 Metro Center Drive, Suite 100
Austin, TX 78744
Delivered by fax: 512.804.4868

Notice of Determination

MDR TRACKING NUMBER: M5-07-0196-01
RE: Independent review for ___

The independent review for the patient named above has been completed.

- Parker Healthcare Management received notification of independent review on 10.31.06.
- Faxed request for provider records made on 10.31.06
- TDI-DWC issued an Order for payment on 11.13.06.
- The case was assigned to a reviewer on 12.6.06.
- The reviewer rendered a determination on 12.26.06.
- The Notice of Determination was sent on 12.26.06.

The findings of the independent review are as follows:

Questions for Review

Medical necessity of denied services shipping costs, Braun power doors, exhaust modification, remote control, non-skid floor and E-Z lock tie down. The date of service in dispute is 12.15.05.

Determination

PHMO, Inc. has performed an independent review of the proposed care to determine if the adverse determination was appropriate. After review of all medical records received from both parties involved, the PHMO, Inc. physician reviewer has determined to **overturn the denial** on the denied service(s): Braun power doors, exhaust modification, remote control, non-skid-floor and E-Z lock tie down.

The PHMO, Inc. physician reviewer has also determined to **uphold the denial** on the denied service:
Shipping costs.

Summary of Clinical History

Mr. ___ sustained an injury on ___, while employed .

Clinical Rationale

Mr. ___ is a spinal cord-injured individual with a permanent spinal cord injury for life. The wheelchair accessible van is an essential piece of equipment for his ability to be mobile within the community. There appears to be some discussion in order for Mr. indicating why this van and the particular modifications are excessive. From a medical standpoint, I can see how all these medical modifications are necessary for a mid thoracic paraplegic gentleman to use a van, certainly for fast exit issues of inclement weather are of importance; if the chair gets slippery or falls or slides off the stand, or he becomes injured as a result of the prolonged period of time getting in and out of the van by trying to rush due to inclement weather, he could cause harm to himself.

I am not an expert in the specifics of the van, but the overall need for a wheelchair lift, remote control doors, and easy-lock tie downs are all essential. If exhaust modification was required in order to make the modifications for the doors and the lift, then that is considered to be required. Non-skid floors are essential so that no one is injured getting in or out of the van when it is wet.

It is my conclusion that all these modifications are reasonable, with the exception of the excessive freight for shipping the vehicle back and forth. The other requests should be considered appropriate modifications for a mid thoracic paraplegic van modification for wheelchair accessibility.

Clinical Criteria, Utilization Guidelines or other material referenced

This conclusion is supported by the reviewers' clinical experience with over 10 years of patient care.

The reviewer for this case is a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

The review was performed in accordance with Texas Insurance Code 21.58C and the rules of Texas Department of Insurance /Division of Workers' Compensation. In accordance with the act and the rules, the review is listed on the DWC's list of approved providers or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and the treating and/or referring 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.
The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

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.

I hereby verify that a copy of this Findings and Decision was faxed to Texas Department of Insurance /Division of Workers Compensation applicable to Commission Rule 102.5 this 26th day of December, 2006. The Division of Workers Compensation will forward the determination to all parties involved in the case including the requestor, respondent and the injured worker.

_____

Meredith Thomas
Administrator
Parker Healthcare Management Organization, Inc.