



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: Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231	MDR Tracking No.: M5-07-0351-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TEXAS MUTUAL INSURANCE CO, BOX 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...It is our position that Texas Mutual has established an unfair and unreasonable time frame in paying for the services that were rendered to ... Your help in resolving this case is appreciated."

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 statement submitted by Texas Mutual does not address the disputed issues.

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)
11-30-05 – 12-09-05	97545-WH-CA (\$128.00 x 2 days)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$256.00
11-30-05 – 12-09-05	97546-WH-CA (\$64.00 hr. x 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$512.00
	Total Due		\$768.00

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 (e) (5) the amount due the Requestor for the items denied for medical necessity is \$768.00.

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 \$768.00. 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:

02-15-07

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

February 5, 2007

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 #: M5-07-0351-01
 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

This patient sustained a work related injury on ___ when she was moving and unloading boxes, resulting in neck and shoulder pain. The patient has undergone physical therapy, chiropractic treatments, and participation in a work-hardening program.

Requested Service(s)

Work hardening/conditioning (97545-WH-CA), Work hardening each additional hour (97546-WH-CA) provided from 11/30/05 and 12/09/05.

Decision

It is determined that the Work hardening/conditioning (97545-WH-CA), Work hardening each additional hour (97546-WH-CA) provided from 11/30/05 and 12/09/05 was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Review of the medical record documentation reveals that there was sufficient documentation to clinically justify all services rendered as a part of the work hardening program. Official Disability Guidelines and other national treatment guidelines allow for a work hardening program for injuries of this type. The examinations, FCE's and clinical notes document and measure the patient's progress through the program and attained the designated goals and medium level of job classification required by her employment.

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

Information Submitted to TMF for Review

Patient Name: ____
Tracking #: M5-07-0351-01

Information Submitted by Requestor:

- **Summary of Requestor's Position**
- **Report of the MRI of the cervical spine**
- **Report of the study of electromyography and nerve conduction velocity**
- **Initial neurological consultation**
- **History & Physical for Work Hardening Program**
- **PT evaluation**
- **Functional Capacity Evaluation**
- **Work hardening daily notes**
- **Work hardening daily flow sheets**
- **Office notes from Dr. Crockett**

Information Submitted by Respondent:

None