



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:

Rehab 2112
P. O. Box 671342
Dallas, TX 75267-1342

MDR Tracking No.: M5-07-0404-01

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

Position Summary (Table of Disputed Services): "Services were medically necessary."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

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)
1-26-06 - 2-9-06	97545-WH-CA, 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$0.00

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 not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Division has determined that the Requestor is not entitled to reimbursement for the IRO and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

02-15-07

Authorized Signature

Typed Name

Date of Findings and Decision

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.

February 6, 2007

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

Patient: ____
DWC #: ____
MDR Tracking #: M5-07-0404-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-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

According to records received and reviewed, _____ was injured in a work related accident on _____. The injured employee was working for _____ as a propane technician when he was injured. The patient was pulling and washing cylinders when he fell from a 3-5 foot platform and landed on his left outstretched wrist and sustained multiple injuries to his lumbar region and left wrist.

RECORDS REVIEWED

Records were received and reviewed from the insurance carrier and from the treating provider.

Records included but were not limited to:

- Medial Dispute Resolution paperwork
- Carrier's Statement
- Reports from Dr. Padilla
- Records from Rehab 2112
- DD report Dr. Gordon 7% MMI 3-20-2006
- MDR Request from Dr. Parent
- Letters of Medical Necessity
- White Rock MRI of left wrist and lumbar
- Report from Lone Star Radiology
- Reports from Metroplex Diagnostics
- Reports from Dr. Wise
- Work Hardening records
- Accident and Injury records
- 449 pages of provider records

DISPUTED SERVICES

The service under dispute is a work hardening program (97545-WHCA) and each additional hour of work hardening program (97546-WHCA) from 1/26/06 through 2/9/06.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The basis for the determination is based upon the Official Disability Guidelines, Medical Disability Advisor, Medical Fee Guidelines specific to Work Hardening, Industrial Rehabilitation-Techniques for Success, and Occupational Medicine Practice Guidelines. Specifically, a Work Hardening program should be considered as a goal oriented, highly structured, individualized treatment program. The program should be for persons who are capable of attaining specific employment upon completion of the program and not have any other medical, psychological, or other condition that would prevent the participant from successfully participating in the program. The patient should also have specifically identifiable deficits or limitations in the work environment and have specific job related tasks and goals that the Work Hardening program could address. Generic limitations of strength range of motion, etc. are not appropriate for Work Hardening. When considering the entrance criteria of a Work hardening program, the records reflect that _____ does not have a job to return to upon completion of the work hardening program. This does not meet the entrance criteria of a work hardening program in that the patient should have specific attainable employment upon completion of the work hardening program whereas work conditioning, according to the APTA and Industrial Rehabilitation, is a program to restore the patient's ability so the patient can return to work. This is not to say that _____ does not need additional care or that he does not have a significant injury, only that work hardening cannot be supported in this case without specific identifiable goal of employment.

REFERENCES

Official Disability Guidelines
Medical Disability Advisor
Medical Fee Guidelines specific to Work Hardening
Industrial Rehabilitation-Techniques for Success
Occupational Medicine Practice Guidelines

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, 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,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service, or both on this 6th day of February 2007

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli