



Texas Department of Insurance, Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL NECESSITY DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Dr. Suhail Al-Sahli, 1210 A Nasa Rd. 1, Houston, Texas 77058. MFDR Tracking #: M5-08-0057-01, Previous #: M4-07-0264-01. Respondent Name and Box #: HARTFORD UNDERWRITERS INSURANCE, Box 27.

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "...was undergoing Aquatic Therapy for Post Injection Therapy based on her Initial Evaluation that demonstrated physical and psychological factors that were a direct result of her on the job injury and in preparation for her return to work."

Principal Documentation:

- 1. DWC 60 package
2. Total Amount Sought - \$4,000.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

No response was received from the Respondent.

PART IV: SUMMARY OF FINDINGS - MEDICAL NECESSITY ISSUES

Table with 5 columns: Eligible Dates of Service (DOS), CPT Codes and Calculations, Medically Necessary?, Part V Reference, Amount Ordered. Row 1: 9-13-05 - 11-9-05, 97113-AT (\$41.13 x 80 units), [X] Yes [] No, 1 - 6, \$3,290.40. Total Due: \$3,290.40

PART V: REVIEW OF SUMMARY, METHODOLOGY AND 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.

1. These services were denied by the Respondent for medical necessity after a peer review.
2. The Respondent did file a PLN11 which disputed the issue of Psychological Treatment. The Requestor billed with the Diagnosis Codes of "722.0 – Displcmt cerv intervert disc w/out myelop," "722.2 – Displcmt intervert disc site uns w/o myelopa," "841-9 - Sprain/strain site elbow/forearm," and "842.0 – Wrist sprain/strain." The Requestor treated the compensable injury. The CCH Decision and Order of September 20, 2006 is valid. This injury is compensable.
3. Date of service 9-19-05 was also denied by the Respondent as "165-Payment denied/reduced for absence of or exceeded referral. Not treating doctor." Rule 180.20(a) states that a doctor must be on ADL list. Dr. Lawrence Caudell is a doctor of chiropractic. Review of the Division's ADL list shows that the doctor performing these services was credentialed at the time the services were performed per Rule 180.20(a). The Respondent inappropriately denied reimbursement based on denial code "165."
4. Per review of Box 32 on CMS-1500, zip code 77058 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
5. Per Rule 134.202(d) "reimbursement shall be the least of the (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." The lesser of these amounts was the MAR amount as established by this rule.
6. 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) the amount due the Requestor for the items denied for medical necessity is \$3,290.40.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311
 28 Texas Administrative Code Sections 133.308, 134.1, 134.202, 180.20
 Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement and is entitled to a refund of the IRO fee (\$460.00) for the services involved in this dispute. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$3,290.40 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

 Authorized Signature

 Medical Fee Dispute Resolution Officer

1-16-08

 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

P-IRO

An Independent Review Organization
7626 Parkview Circle
Austin, Texas 78731
Phone: 512-346-5040
Fax: 512-692-2924

December 19, 2007

RTDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee

RTDI-DWC #

MDR Tracking #:

M5-08-0057-01

IRO #:

5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed provider board certified and specialized in Chiropractic Treatment. The Reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including: IRO request, Table of dispute, EOB for associates dates, NBC Health Care Center letter to IRO dated 11-26-2007, Daily Therapy notes for associates DOS, Texas Pain Solutions Surgical Center SI joint injection 10-05-2005, 6-30-2005 8-04-2005 8-25-2007 CESI, report Texas pain Solutions 4-15-2005 8-12-2005 9-09-2005, Ultra Diagnostics EMG/NCV report 6-03-2005 and 6-06-2005, MRI report cervical and lumbar spine 5-04-2005, LOMN Nassau Bay Rehab, NBC Health Care Center daily notes associated DOS, x-ray knee and left hand, DDE report 10-13-2005, Theodore Pearlman MD report 9-08-2005, MMPI-2 James Butler PhD, CLC HealthCare Center report 4-12-2005, Nassau Bay Rehab treatment summary.

CLINICAL HISTORY

The claimant sustained a work related injury on ____, when she stepped in a hole and fell. The injured employee injured her neck, back, and knees. The injured employee eventually underwent advanced diagnostics including MRI and EMG. The injured employee underwent therapy, pain management injections, medication, and aquatic therapy. The injured employee was eventually seen by a DDE on 10-13-2005 and assessed at MMI.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of Aquatic therapy, exercises for the dates 9/13/07 thru 11/9/07.

DETERMINATION / DECISION

The Reviewer disagrees with the determination of the insurance carrier.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services: 97113-AT-Aquatic Therapy for DOS: 9-13-2005 THROUGH 11-09-2005 are medically necessary. Post-operative/injection aquatic therapy is essential in the recovery and/or treatment for the injuries and/or surgery. Post-injection aquatic treatment is consistent with medical standards/guidelines/and protocols. The records reviewed do provide adequate evidence to support the necessity for the services in review. The claimant progressed under the current post-operative treatment plan.

Screening Criteria

1. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

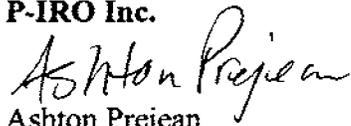
P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer

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.

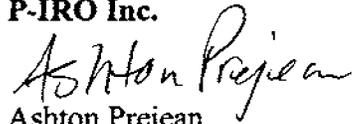
The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent DWC via facsimile, U.S. Postal Service or both on this 19th day of December, 2007.

Name and Signature of P-IRO Representative:

Sincerely,

P-IRO Inc.



Ashton Prejean

President & Chief Resolutions Officer