



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor=s Name and Address:	MDR Tracking No.: M5-05-2824-01
All Star Chiropractic and Rehab 8208 Bedford-Euleess Road N. Richland Hills, TX 76180	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
American Home Assurance Company, Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "I do not think any doctor would have fault in the treatment that was rendered to this claimant showing that he had a 4-5 mm recurrent herniation at L5-Si. This was read by two radiologists."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary states, "The carrier submits that the requestor has already been reimbursed for all reasonable, necessary, and related medial treatment...Evidentiary objection: The documentation submitted by the Requestor is inadmissible as there is insufficient evidence the proffering witness has personal knowledge of the exhibits."

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)
7-30-04 – 9-15-04	CPT codes 97110, 98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,974.44
7-30-04 – 9-15-04	CPT codes 97012, 97032, 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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. The amount due the requestor for the items denied for medical necessity is \$2,974.44.

Based on review of the disputed issues within the request, the has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 8-29-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The carrier denied CPT Code 99080-73 on 8-6-04, 8-20-04, 8-25-04, and 9-3-04 with a "V" for unnecessary medical treatment based on a peer review; however, the DWC-73 is a required report per Rule 129.5 and is not subject to an IRO review. Medical Review has jurisdiction in this matter; Recommend reimbursement of \$60.00 (\$15.00 X 4 DOS).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 129.5 and 134.202(c)(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, e Division has determined that the requestor is entitled to reimbursement in the amount of \$3,034.44 and is entitled to a refund the amount of the IRO fee (\$460.00) within 30 days of receipt of this order. The Division hereby **ORDERS** the insurance carrier 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:

Authorized Signature

Typed Name

11-22-05

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

October 7, 2005

Amended Letter: November 11, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking # : M5-05-2824-01
IRO Certificate #: IRO4326

The TMF Health Quality Institute has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC 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 30 year-old male injured his back on ____ while pulling a door out of a trash compactor at his place of employment. He has been treated with medications, therapy and epidural steroid injections.

Requested Service(s)

Mechanical traction, electrical stimulation, ultrasound, therapeutic exercises, chiropractic manipulation for dates of service 07/30/04 through 09/15/04.

Decision

It is determined that there is medical necessity for the therapeutic exercises and chiropractic manipulation for dates of service 07/30/04 through 09/15/04 to treat this patient's medical condition.

It is determined that there is no medical necessity for the mechanical traction, electrical stimulation, and ultrasound to treat this patient's medical condition.

Rationale/Basis for Decision

Magnetic resonance imaging revealed an apparent recurrent L5 disc bulge and needle electromyogram confirmed his condition. Medical record documentation indicates this patient has progressed into active therapy while continuing to receive passive therapy. National treatment guidelines allow for one to two months of passive therapy and three to six months of active therapy for this type of

injury. There is sufficient clinical documentation to support the chiropractic manipulation and therapeutic exercises for dates of service 07/30/04 through 09/15/04; however, there is no clinical documentation or justification to warrant the passive therapies including mechanical traction, electrical stimulation and ultrasound during the same time period. Therefore, the therapeutic exercises and chiropractic manipulation for dates of service 07/30/04 through 09/15/04 are medically necessary to treat this patient's medical condition. The mechanical traction, electrical stimulation, and ultrasound are not medically necessary to treat this patient's medical condition.

Sincerely,

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

Information Used by TMF in Decision

Patient Name: ____

TWCC ID #: M5-05-2824-01

Medical record documentation provided:

- **Requests**
- **Progress Notes**
- **Diagnostic Tests**
- **Procedures**
- **Claims**