



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.: M5-05-3055-01
Nicholas Padron, M. D. 7125 Marvin D Love #107 Dallas, TX 75237	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included the TWCC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "Attached is supporting documentation showing that services rendered are medically necessary."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included the TWCC 60 form.

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)
11-24-04 – 12-8-04	CPT codes 97110, 97035, 97032, 97530, 95851, 95831	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$719.14

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 \$719.14.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 (\$650.00) 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 \$719.14. 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

10-13-05

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

September 26, 2005

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

RE: Injured Worker:
MDR Tracking #: M5-05-3055-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 §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 TMF physician reviewer who is board certified in Family Practice which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1977. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 57 year-old female injured her right cervical spine and right anterior shoulder on ___ while moving a heavy steel door. She has been treated with medications, therapy and epidural steroid injections.

Requested Service(s)

Therapeutic exercises, ultrasound, electrical stimulation – manual, therapeutic activities, range of motion, muscle testing for dates of service 11/24/04 through 12/08/04

Decision

It is determined that there is medical necessity for the therapeutic exercises, ultrasound, electrical stimulation – manual, therapeutic activities, range of motion, muscle testing for dates of service 11/24/04 through 12/08/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. A trial course of six-weeks of physical therapy is acceptable and reasonable. Medical record documentation does not indicate these services were provided prior to 11/24/04 so there is no duplication of services. Therefore, the therapeutic

exercises, ultrasound, electrical stimulation – manual, therapeutic activities, range of motion, and muscle testing for dates of service 11/24/04 through 12/08/04 is medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

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

GBS:dm

Attachment

Information Used by TMF in Decision

Patient Name:

TWCC ID #: M5-05-3055-01

Medical record documentation provided:

- Progress Notes
- Functional capacity evaluation
- Diagnostic Tests