



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.: M5-06-0130-01
Neuromuscular Institute of Texas 9502 Computer Drive, Suite 100 San Antonio, TX 78229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Southwestern Bell Telephone LP, Box 17	Employer's Name:
	Insurance Carrier's No.:

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, "Treatment and therapies were consistent and within the scope of chiropractic practice. Treatment was billed within the Chiropractor's usual and customary charges."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 Table of Disputed Services form. The carrier indicated that it will pay for some services.

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)
9-13-04 – 9-30-04	Paraffin Bath, Therapeutic Exercises, Manual Therapy Technique, Ultrasound, OT, Office Visit	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
9-13-04 – 2-18-05	Neuromuscular Reeducation	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
12-01-04 – 2-18-05	Paraffin Bath, Therapeutic Exercises, Manual Therapy Technique, Ultrasound, OT, Office Visit	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,647.63

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,647.63.

The insurance carrier submitted copies of checks showing that CPT code 99455 on 9-13-04 and CPT code 99080-73 on 1-10-05 were paid. These services will not be a part of this review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 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, 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 \$1,647.63. 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:

11-23-05

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

November 3, 2005
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

Amended Letter: November 18, 2005

RE: Claim #:
Injured Worker:
MDR Tracking #:M5-06-0130-01
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 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. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her 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. 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 injured her shoulders, elbows, and hands. The patient has been treated with surgeries, epidural steroid injections, and chiropractic care.

Requested Service(s)

Neuromuscular reeducation, paraffin bath, therapeutic exercises, manual therapy technique, ultrasound, OT, and office visit provided from 09/13/2004 through 02/18/2005.

Decision

It is determined that all treatments provided on 09/13/2004, 09/22/04, 09/29/2004, and 09/30/2004 and all of the neuromuscular reeducation were not medically necessary to treat this patient's condition. All neuromuscular reeducation provided during 09/13/2004 through 02/18/2005 was not medically necessary to treat this patient's condition. All remaining treatments (paraffin bath, therapeutic exercises, manual therapy technique, ultrasound, OT, and office visit) were medically necessary except for the above dates of service.

Rationale/Basis for Decision

The medical record documentation does not substantiate that the services performed on 09/13/2004, 09/22/2004, and 09/30/2004 fulfilled the statutory requirements 1 for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. Specifically, the patient's pain rating was 4/10 on 09/13/2004 and remained at 4/10 on 09/30/2004.

In regard to the neuromuscular reeducation services (97112), there was nothing in either the diagnosis or the physical examination findings on this patient that demonstrated the type of neuropathology that would necessitate the application of this service. According to a Medicare Medical Policy Bulletin², "This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, motor skill, and proprioception. Neuromuscular reeducation may be reasonable and necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, hypo/hypertonicity). The documentation in the medical records must clearly identify the need for these treatments." In this case, the documentation does not fulfill these requirements, rendering the performance of this service medically unnecessary.

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 (other than a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceeding, within ten (10) days of your receipt of this decision.

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceeding/Appeals Clerk, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment
GBS:dm

¹ Texas Labor Code 408.021

² HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 04/01/1993 (Y-1B)

