



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: Work Ready Rehab 500 Century Plaza Dr #165 Houston TX 77073	MDR Tracking No.: M5-06-0219-01 Previously: M5-05-1476-01
Respondent's Name and Address: ZNAT Insurance Box 47	Claim No.:
	Injured Employee's Name:
	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC 60 package, Explanations of Benefits and CMS 1500's.
Position summary: "Treatment was medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response and peer review. Position summary states in part, "...The dispute appears to be a medical necessity dispute regarding physical therapy treatment..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due (if any)
3-1-04 to 5-3-04	97035, 97124, 97110-59, 97140, 97150, 97750-59, and 97002-59	<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 not prevail on the disputed medical necessity issues.

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 Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Medical Dispute Officer

11-15-05

Authorized Signature

Typed Name

Date

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.

September 30, 2005

April 15, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

CORRECTED REPORT

Re: Medical Dispute Resolution
Old MDR #: M5-05-1476-01
New MDR#: M5-06-0219-01
TWCC#:
Injured Employee:
DOI:
IRI's IRO Cert. #: IRO 5055

Dear Ms. _____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is board certified in Orthopedic Surgery, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

REVIEWER'S REPORT
Old MDR# M5-05-1476-01
New MDR# M5-06-0219-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Letter of medical necessity

Physical therapy progress notes 03/01/04 – 04/21/04

Physical therapy daily notes 03/02/04 – 05/05/04

Nerve conduction study 02/04/04

Information provided by Respondent:

Physician bill review findings 07/13/04 & 04/07/04

Request for reconsideration (Not dated)

Orthopedic consultation 01/05/04

Information provided by Orthopedic Surgeon:

Office notes 06/10/04 – 05/05/04

Clinical History:

The patient is a 48-year-old gentleman who suffered a work-related injury to his low back on . He has been treated conservatively for a lumbar strain and possible L5/S1 radiculopathy. The patient was treated with approximately 6 months of physical therapy. The patient did not receive any other treatment other than symptomatic treatment with medications and physical therapy. He did receive an orthopedic second opinion at the Baylor College of Medicine.

Disputed Services:

Ultrasound therapy, massage therapy, therapeutic exercises, manual therapy, group therapeutic procedures, physical performance testing, and physical therapy re-evaluation during the period of 03/01/04 thru 05/03/04.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the therapy, exercises, testing and procedures in dispute as stated were not medically necessary in this case.

Rationale:

The treating doctor failed to adequately document the reasons why the coordinated physical therapy program would be beneficial over a home exercise program in this patient without significant neurological deficits or range of motion deficits. Most of his symptoms are subjective, and therapy beyond the acute 6-8 weeks after the date of injury is not justified without adequate documentation. Without supplemented documentation to justify this physical therapy, it is deemed as medically unnecessary.