



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: James Tanner, D. C. 5350 S. Staples Ste. 210 Corpus Christi, Texas 78411	MDR Tracking No.: M5-06-0362-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance, Box 28	Date of Injury:
	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, "I believe that these treatments were necessary. By treating injured worker and occasionally having injured worker undergo epidural steroid injection, we are able to continue allowing Ronda to work without restrictions in her job capacity."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form and Explanations of Benefits.

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)
10-27-04 – 6-3-05	CPT codes 97012, 98940, 97124, 97110, G0283, 97140	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,646.11

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 \$1,646.11.

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 \$1,646.11. 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:

Donna Auby

11-30-05

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.

November 29, 2005

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-06-0362-01
DWC#:
Injured Employee: ____
DOI: ____
SS#: ____
IRO Certificate No.: 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 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 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 licensed in chiropractic, and is currently on the DWC Approved Doctor List.

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 a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme
General Counsel
GP:dd

REVIEWER'S REPORT
M5-06-0362-01

Information Provided for Review:

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

Information provided by Requestor:

Correspondence

Office Notes 10/27/04 – 06/03/05

Daily Notes 11/19/04 – 12/06/04

Information provided by Respondent:

Correspondence

Pain Management:

Office Notes 11/19/02 – 07/29/03 and 11/03/04 – 11/16/04

OR Report 11/16/04

Radiology 10/16/02

Clinical History:

Patient underwent ESI and physical medicine treatments after sustaining injury at work on ____.

Disputed Services:

97012 mechanical traction, 98940 chiropractic manipulation, 97124 massage, 97110 therapeutic exercises, G0283 electrical stimulation, 97140 manual therapy technique from 10/27/04 through 06/03/05.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were medically necessary in this case.

Rationale:

Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. With documentation of improvement in the patient's condition and restoration of function, continued treatment may be reasonable and necessary to effect additional gains.

In this case, there is more than adequate documentation of objective and functional improvement in this patient's condition. Specifically, the patient's pain ratings significantly decreased, her spinal ranges of motion increased and she remained working. Without question, the medical records fully substantiate that the disputed services fulfilled statutory requirements¹ for medical necessity since the patient obtained relief, promotion of recovery was accomplished and there was an enhancement of the employee's ability to retain employment.

¹ Texas Labor Code 408.021