



**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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Mid Valley Physical Therapy 1810 E. 8 <sup>th</sup> Street Weslaco, TX 78596	MDR Tracking No.: M5-06-0600-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Given the success of physical therapy for the injured worker we feel that this qualifies it as medically necessary service."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

#### 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)
5-6-05 – 6-6-05	CPT code 97110 (\$33.56 X 34 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,141.04
5-6-05 – 6-6-05	CPT code 97001	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$90.56
5-6-05 – 6-6-05	CPT code 97035 (\$14.63 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$29.26
5-6-05 – 6-6-05	CPT code G0283 (\$13.61 X 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$163.32
5-6-05 – 6-6-05	CPT code 97002	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$47.70
	Grand Total		\$1,471.88

#### 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 \$1,471.88.

**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 (\$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 \$1,471.88. 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:

2-22-06

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

February 14, 2006

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

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M5-06-0600-01  
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 DWC §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 1966. 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 patient sustained a work-related injury on \_\_\_ when he experienced increased low back pain when he was performing repetitive lifting and carrying of heavy pipes on his shoulders. An MRI performed in September of 2004 revealed bulging discs in the lumbosacral spine. A portion of the patient's therapy included physical therapy treatments.

### Requested Service(s)

Therapeutic exercises (97110), physical therapy evaluation (97001), ultrasound (97035), electrical stimulation (G0283), and physical therapy re-evaluation (97002) provided from 05/06/05 thru 06/06/05.

### **Decision**

It is determined that the therapeutic exercises (97110), physical therapy evaluation (97001), ultrasound (97035), electrical stimulation (G0283), and physical therapy re-evaluation (97002) provided from 05/06/05 thru 06/06/05 were medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The modalities requested for this patient and the scheduled length/frequency of treatments are well in keeping with recognized treatment modalities for his diagnosis – back strain with MR changes consistent with spondylolisthesis, mild stenosis, and thecal sac compression and EMG changes consistent with a peripheral neuropathy. The report indicating that prior treatments had helped, at least subjectively and perhaps objectively, also support the indication that the prescribed treatment modalities could be expected to improve patient's symptomatology.

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 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,

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