



## 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:<br><br>Syzygy Associates, L.P.<br>P. O. Box 25006<br>Fort Worth, TX 76180 | MDR Tracking No.: M5-06-0806-01 |
|   | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br><br>American Home Assurance Company, Box 19                           | 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.

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

Documents include the DWC-60 response. Position Summary states, "No further payment was recommended towards the amount in dispute."

#### 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) |
|---|--|---|--------------------------------|
| 3-20-05, 4-01-05<br>(withdrawn by requestor),<br>4-14-05 (withdrawn by requestor) | CPT code 97110   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$34.96                        |
| 3-30-05   | CPT code 97140   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$33.04                        |
| 3-20-05 – 9-9-05  | CPT code 97140 (except for 3-30-05),<br>97110 (except for 3-20-05), 97530, 97032, 97004, 97010 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 0                              |
|   | Grand Total  |   | \$68.00                        |

#### 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 majority of the disputed medical necessity issues.

A Revised Table of Disputed Services, sent by the requestor on 3-1-06, was used for this review. This Table showed that

some items had been withdrawn by the requestor.

**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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$68.00. 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 by:

3-09-06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and Decision

**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 23, 2006

**Amended Letter: March 3, 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 #: M5-06-0806-01  
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 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. 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 she was walking down stairs, stepped down to the last step, slid and missed the last step. This resulted in injury to her lumbar spine, left shoulder, left elbow, and hip. The patient has undergone surgery and chiropractic treatments.

### Requested Service(s)

97140-Manual therapy technique, 97110-Therapeutic exercises, 97530-Therapeutic activities, 97032-Electrical stimulation, 97004-Occupational therapy re-evaluation and 97010-Hot/cold packs provided from 03/20/2005 through 09/09/2005.

### **Decision**

It is determined that the 97110-therapeutic exercises performed on 03/20/2005, 04/01/2005, and 04/14/2005; and the 97140-manual therapy technique performed on 03/30/2005, were medically necessary to treat this patient's condition.

It is determined that the remainder of the 97110-therapeutic exercises and the 97140-manual therapy technique as well as the 97032-Electrical stimulation, 97004-Occupational therapy re-evaluation and 97010-Hot/cold packs provided from 03/20/2005 through 09/09/2005 were not medically necessary.

### Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following surgery and it would be reasonable to perform this therapy over a six-week period. Therefore, the 97110-therapeutic exercises performed on 03/20/2005, 04/01/2005, and 04/14/2005; and the 97140-manual therapy technique performed on 03/30/2005, were medically necessary to treat this patient's condition.

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. In this case, there is no documentation of objective or functional improvement in this patient's condition.

The records failed to substantiate that the disputed services fulfilled statutory requirements<sup>1</sup> 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 employment. Specifically, the patient's pain rating was 6/10 on 05/16/2005 and remained at 6/10 on 09/09/2005 at the termination of the disputed treatment. The medical record documentation does not indicate any material improvement.

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

## Information Submitted to TMF for Review

**Patient Name:**

**Tracking #: M5-06-0806-01**

### **Information Submitted by Requestor:**

- **Table of disputed services**
- **EOBs**
- **Decision letters**
- **Therapy Notes**
- **Requests for reconsideration**

### **Information Submitted by Respondent:**

- **Decision Letters**
- **Independent Review Organization Summary**
- **Employer's Report of Injury**
- **Member Profile Report**
- **Radiology Reports**
- **Work Status Reports**
- **Initial Consultation**
- **Progress Reports**
- **Report of MRI of left shoulder**
- **Report of MRI of spine**
- **PEER Review**
- **Chiropractic History and Physical**
- **Initial Reports**
- **Video Surveillance Report**
- **Evaluation/Management Medical Reports**
- **Follow up Reports**
- **Orthopedic Clinic Notes**
- **Letter of Medical Necessity**
- **Nerve Conduction Study**
- **Operative Reports**
- **Psychological Evaluation Report**
- **Pre-operative History & Physical**
- **Pre-operative Consultation**
- **Range of Motion Report**
- **Independent Medical Review**
- **Physical Performance Evaluations**
- **Physical Therapy/Daily Notes/Chronic Pain Management notes**