



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:  Integra Specialty Group, P. A. 517 North Carrier Parkway, Suite G Grand Prairie, TX 75050	MDR Tracking No.: M5-06-0857-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  ZNAT Insurance Company, Box 47	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, "The carrier failed to provide any request for reconsideration response EOB's for the outstanding dates of service."

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

No response received.

#### 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)
5-16-05 – 6-17-05	CPT code 99213 (\$68.24 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$204.72
5-16-05 – 6-17-05	CPT code 99211	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$27.86
5-16-05 – 6-17-05	CPT code 97140 (\$34.13 X 10 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$341.30
5-16-05 – 6-17-05	CPT code 97110 (\$36.14 X 30 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,084.20
5-16-05 – 6-17-05	CPT code 96004 (\$152.75 X DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$152.75
	CPT codes 99211 and 99213 (more than one per week), 97032, 97035	<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 prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$1,810.83.

**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 \$1,810.83. 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:

4-11-06

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

March 7, 2006

**Corrected Letter: March 15, 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 #: M5-06-0857-01  
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 a co-worker lowered a metal bar. He has suffered from low back pain and radicular symptoms in the lower extremities since the accident. He was evaluated and diagnostic tests were performed. The patient has been treated with chiropractic care, physical therapy, and medication. He also received three epidural steroid injections and post injection care after each injection.

### Requested Service(s)

(99211/99213) Office visits, (97140) Manual therapy technique, (97110) Therapeutic exercises, (97032) Electrical stimulation, (97035) Ultrasound, (96004) Physician review and interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report provided from 05/16/2005 through 06/17/2005.

### **Decision**

It is determined that during the dates of service from 05/16/2005 through 06/17/2005, office visits one per week (99213), manual therapy techniques (97140), therapeutic exercises (97110), and physician review and interpretation of comprehensive computer based motion analysis (96004) were medically necessary to treat this patient's condition.

It is determined that office visits (99211/99213) more than once per week, passive therapy to include electrical stimulation (97032), and ultrasound (97035), were not medically necessary.

### Rationale/Basis for Decision

National treatment guidelines allow for post injection care up to 6 visits to include active therapy. Guidelines allow for up to one office visit per week during treatment to allow for proper assessment and evaluation. Physician review and interpretation of computer based motion analysis are also allowed. Guidelines, however, do not allow for the continuation of passive therapy several months after a date of injury or in conjunction with post injection care.

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 #: M5-06-0857-01

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

- IRO Position Statement
- Table of disputed services
- Procedure reports
- Physician Review Findings
- SOAP Notes

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

- Required Medical Evaluation
- Physician Review Findings