



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: <input checked="" type="checkbox"/> Health Care Provider <input type="checkbox"/> Injured Employee <input type="checkbox"/> Insurance Carrier	
Requestor's Name and Address: The Chalon Corporation P.O. Box 2500 Rockwall, TX 75087	MDR Tracking No.: M5-06-1386-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: 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. Position Summary states, "The carrier has not taken into account that the injured worker is 84 years old and has other health issues that prolonged her recovery."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC-60 response. Position Summary states, "File reviewed and denied as unnecessary medical, thus no further payment was recommended."

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)
3-28-05 – 5-12-05	CPT codes 97010, 97016, 97032, 97110, 97002	<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.

Dates of service 3-14-05 – 3-17-05 were untimely filed and will not be a part of this review per Rule 133.308 (e).

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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby, Medical Dispute Officer

5-17-06

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

May 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 #: M5-06-1386-01
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 Orthopedic Surgery 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 1969. 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 tripped over a box which resulted in a severe injury to her left shoulder. A portion of the patient's care was provided by physical therapy.

Requested Service(s)

(97010) Hot/Cold pack therapy; (97016) Vasopneumatic devices; (97032) Electrical Stimulation; (97110) Therapeutic Exercises; and (97002) Physical therapy re-evaluation provided from 03/28/05 to 05/12/05.

Decision

It is determined that the (97010) Hot/Cold pack therapy; (97016) Vasopneumatic devices; (97032) Electrical Stimulation; (97110) Therapeutic Exercises; and (97002) Physical therapy re-evaluation provided from 03/28/05 to 05/12/05 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

For physical therapy services to be reasonable there must be a reasonable expectation of improvement in symptoms and/or objective physical findings. Significant diminished range of motion is the expected result when elderly osteoporotic patients suffer juxta-articular fractures such as this patient suffered as a result of a fall on 12/15/2004. Physical therapy is usually instituted early in the management of proximal humerus fractures. Usually the findings at 10-12 weeks post fracture are established and rarely improve except over a very long term of a home program. This program of physical therapy had no reasonable expectation of improvement and therefore, should be considered to be without reasonable medical necessity.

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,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name:

Tracking #: M5-06-1386-01

Information Submitted by Requestor:

- Letter of Medical Necessity
- Exercise Flow Sheets
- Table of Disputed Services
- Letters from Joyce Ford
- Claim forms
- Physical Therapy Daily Summaries
- Re-Evaluation Plan of Care

Information Submitted by Respondent:

None