



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: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1576-01
John D. Carlson, D. C. 6905 West Gate Blvd. Ste. A. Austin, TX 78745	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Zenith Insurance Company, Box 47	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 that the peer review was performed before the dates of service in dispute and, therefore, no review was done on these dates of service.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Zenith continues to believe that the disputed services were not medically necessary."

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)
8-19-05 – 9-16-05	CPT code 98941 (\$46.24 X 9 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$416.16
8-19-05 – 9-16-05	CPT code 97110 (\$35.00<MAR X 9 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$315.00
8-19-05 – 9-16-05	CPT code 97112 (\$35.00<MAR X 9 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$315.00
	Total		\$1046.16

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 \$1046.16.

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 \$1046.16. 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:

6-19-06

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

June 5, 2005

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 #: M5-06-1576-01
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 he slipped while working in a walk-in freezer and fell, hitting his knees on the floor. This resulted in immediate pain in his mid-back and neck. The patient has undergone chiropractic therapy.

Requested Service(s)

Chiropractic manipulative treatment (98941), therapeutic exercises (97110), and neuromuscular re-education (97112) provided from 08/19/2005 through 09/16/2005.

Decision

It is determined that the Chiropractic manipulative treatment (98941), therapeutic exercises (97110), and neuromuscular re-education (97112) provided from 08/19/2005 through 09/16/2005 were all medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Supporting documentation for additional treatment must be furnished when exceptional factors or extenuating circumstances are present. (E) Evidence objective functional improvement is essential to establish reasonableness and medical necessity of treatment. In this case, all of those criteria were met and satisfied in the treatment of this patient.

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 documentation of objective and functional improvement in this patient's condition along with documentation that the patient's pain was relieved. Therefore, the medical records fully substantiate that the disputed services fulfilled the 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 return to or retain employment.

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

¹ Texas Labor Code 408.021

Information Submitted to TMF for Review

Patient Name: ____ Tracking #: M5-06-1576-01

Information Submitted by Requestor:

- Request for Reconsideration
- Chiropractic Examination
- Chiropractic Office notes
- Radiological Report
- Chiropractic Care Schedule
- Home Exercise Program
- Letter from Dr. Carlson
- New Patient Evaluation
- Retrospective medical review
- Report of Medical Evaluation
- Review of Medical History and Physical Exam
- Evaluation by Dr. Singleton

Information Submitted by Respondent:

None