



**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:  JCMLR P.O. Box 1660 San Antonio, TX 78228	MDR Tracking No.: M5-06-1622-01
	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**

Position summary states, "See letter of medical necessity."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

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

Position summary states, "...After review of this request, no further payment was recommended towards the amount in dispute..."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. One EOB

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
6-24-05 – 9-23-05	97110 (\$33.56 x 23 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$771.88
6-24-05 – 9-23-05	97140 (\$27.02 <MAR x 23 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$621.46
6-24-05 – 9-23-05	97150 (\$20.78 x 66 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,371.48
6-24-05 – 9-23-05	97012 (\$17.76 <MAR x 7 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$124.32
6-24-05 – 9-23-05	99203 (\$97.80 <MAR x 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$97.80
6-24-05 – 9-23-05	98940 (\$26.66 <MAR x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$53.32
	Grand Total		\$3,040.26

**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.

**P.O. Box 855  
 Sulphur Springs, TX 75483  
 903.488.2329 \* 903.642.0064 (fax)**

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 \$3,040.26.

**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 Respondent 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 \$3,040.26. The Division hereby **ORDERS** the Respondent 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:**

_____	Medical Dispute Officer	7-24-06
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.**



We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. 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, 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.

Sincerely,

The image shows the initials 'JC' in a large, bold, serif font. The 'J' is lowercase and the 'C' is uppercase. The letters are black and have a classic, slightly ornate design.

Jeff Cunningham, DC  
Office Manager

# **INDEPENDENT REVIEW INCORPORATED**

## **REVIEWER'S REPORT CASE NUMBER**

### **Information Provided for Review:**

1. DWC Assignment
2. Carrier records
3. PT Notes from Spiro Ioannidis, DC

### **Clinical History:**

This patient was injured on the job with Wal-Mart when she was pulling a pallet that was fully loaded with soft drinks and felt a pain in the low back. Carrier notes indicate peer reviews were performed and treatment denied because of the lack of medical necessity for physical medicine on a low back sprain/strain. X-rays of the spine were taken on May 15, 2005 and were negative for pathologies. A MRI was performed on June 16, 2005 which indicated a 2 mm protrusion with some impact on the thecal sac. The level was reported to be at L3-4. The patient underwent facet injections by Dr. Dmitriy Buyanov, MD. She underwent behavioral medicine consultations at Buena Vista Workskills on September 8, 2005. The patient was found to be at MMI on February 22, 2006 by Thimios Partalamas, DC and was assessed a 5% impairment.

### **Disputed Services:**

The carrier has denied the medical necessity of therapeutic exercises, manual therapy, therapeutic procedures, neuromuscular re-education, mechanical traction, office visits and chiropractic manipulation from June 24, 2005 through September 23, 2005

### **Decision:**

I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE.

### **Rationale:**

The patient's condition was documented by the healthcare provider as being serious enough to warrant the treatment that she was given. The patient was attempting to work in light duty while receiving treatment and was a motivated patient. The records do indicate that the patient continued to receive benefit from the treatment rendered and that the treatment was helping her to continue her work. As a result, the treatment is found to be reasonable and necessary.

### **Screening Criteria/Literature Utilized:**

TCA Guidelines, Guidelines of the Mercy Conference.