



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 Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestors Name and Address: Kevin Strathdee, D.C. 2121 N. Main Street Fort Worth, Texas 76106	MDR Tracking No.: M5-06-1842-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Medically Necessary for Physical Rehab."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

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

Respondent's Position Summary: "The charges were denied based on a retrospective physician review as unnecessary medical ANSI "50". No additional payment is recommended."

Principle Documentation:

1. Response to DWC 60

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-09-05 to 11-28-05	97010 * see note below	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
11-09-05 to 11-28-05	G0283 (1 unit @ \$14.16 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$70.80
11-09-05 to 11-28-05	97110 (1 unit @ \$34.93 X 2 units X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$419.16
11-23-05	99212	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$48.03
	*Note: CPT code 97010 per Rule 134.202 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code.		
	<b>TOTAL DUE</b>		\$537.99

#### 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 disputed medical necessity issues.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)  
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

**PART VII: DIVISION FINDINGS AND ORDER**

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 entitled to reimbursement in the amount of \$537.99. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Order by:

10-06-06

\_\_\_\_\_  
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.**

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

### MODIFICATION 9/18/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1842-01
Name of Patient:	
Name of URA/Payer:	Kevin Strathdee, DC
Name of Provider: (ER, Hospital, or Other Facility)	Texas Injury Clinic
Name of Physician: (Treating or Requesting)	Kevin Strathdee, DC

August 16, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

**MODIFIED 9/18/06**

#### DOCUMENTS REVIEWED

1. Correspondence, examination and treatment records from the provider
2. Carrier reviews
3. EOBs
4. Physical Performance Evaluation dated 10/25/05
5. Physical Performance Evaluation dated 11/30/05
6. Diagnostic Imaging Reports
7. Examination Reports of Ved Aggarwal, M.D.
8. Procedure Notes of Ved Aggarwal, M.D.
9. Reports of Charles Marable, M.D.

10. Report of Jacob Rosenstein, M.D.
11. EMG/NCV Report
12. Records of Concentra Medical Centers
13. Report of Patrick Donovan, M.D.
14. Records of USMD Hospital at Arlington

#### CLINICAL HISTORY

Claimant underwent diagnostic imaging, ESI and physical medicine treatments after sustaining injury at work on \_\_\_\_ when a box fell from the top of a stacked pallet and landed on his head.

#### REQUESTED SERVICE(S)

G0283 – Electrical stimulation; 97110 – Therapeutic exercises; 99212 – Office visit; and 97010 – hot/cold pack from 11/09/05 through 11/28/05.

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

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 full documentation of objective and functional improvement in this patient's condition. Specifically, the Physical Performance Evaluation dated 10/25/05 (just prior to the initiation of the disputed treatment) and the Physical Performance Evaluation dated 11/30/05 (at the termination of the disputed treatment) completely document that the claimant's cervical strength and cervical ranges of motion significantly increased.

Therefore and without question, the medical records fully substantiate that the disputed services fulfilled statutory requirements<sup>1</sup> 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.

#### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and 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.

## 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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell