



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-2095-01
Neuromuscular Institute of Texas – P. A. 9502 Computer Drive, Suite 100 San Antonio, TX 78229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...All treatments and therapies were performed to relieve pain and the effects of the compensable injury to the injured employee. Provided dates of service were s/p surgical modalities and strength/range of motion exercises that were seen as medically necessary by three different providers. Per Title 5 Subchapter B Medical Benefits section 408.021(a) an employee is entitled to all health care reasonable required by the nature of the injury as needed..."

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, "Denied as not medically necessary per peer review."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. Peer Review
3. EOB's.

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)
8-22-05, 10-21-05	99213 (\$61.89 x 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$123.78
8-22-05, 10-21-05	99080-73 (\$15.00 x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
9-13-05	97004	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$57.21
10-18-05	95861	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$118.92 < MAR
10-18-05	95903 (\$80.34 x 2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$160.68
10-18-05	95904 (\$63.34 x 3 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$190.02
10-18-05	95936 (\$47.36 x 3.4 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$161.02
8-12-05 – 10-21-05	97035, 97110, 97140-59, G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Grand Total			\$630.64

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.

Dates of service 7-28-05 through 8-3-05 per Rule 133.308(e)(1) were not timely filed and are ineligible for review.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the majority of the disputed medical necessity issues. The amount due the Requestor for the items denied for medical necessity is \$630.64.

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 413.011 and 413.031

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 a refund of the paid IRO fee. The Division has determined that the Requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$630.64. 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:

Authorized Signature

Typed Name

10-16-06

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

September 29, 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 #: M5-06-2095-01
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 ---- while working in data entry. This resulted in numbness in her hands and increased pain in both forearms coming up towards the elbows. She has been treated with medications, chiropractic treatments, occupational therapy, and surgery.

Requested Service(s)

97035-Ultrasound, 97110- Therapeutic exercises, 97140-49- Manual therapy technique, G0283- Electrical stimulation, 99213- Office visits, 99080-73- Special reports, 95861- Needle electromyography-extremities, 95904- Sensory nerve, each nerve, 97004- Occupational therapy re-evaluation, 95903-Nerve conduction with F wave, 95936- H reflex study, provided from 08/12/05 to 10/21/05.

Decision

It is determined that the 99213- Office visits, 99080-73- Special reports, 95861- Needle electromyography-extremities, 95904- Sensory nerve, each nerve, 97004- Occupational therapy re-evaluation, 95903-Nerve conduction with F wave, 95936- H reflex study, provided from 08/12/05 to 10/21/05 were medically necessary to treat this patient's condition.

It is determined that the 97035-Ultrasound, 97110- Therapeutic exercises, 97140-49- Manual therapy technique, G0283- Electrical stimulation provided from 08/12/05 to 10/21/05 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient sustained a work-related injury on ___ while working in data entry. This resulted in numbness in her hands and increased pain in both forearms coming up towards the elbows. Over the course of time she had an aggressive treatment program that included chiropractic care, therapy, medication and surgical intervention. Multiple surgeries were performed with the last on 05/04/05. On 05/22/05 an aggressive post-operative rehabilitation program was begun and included some 21 therapy sessions over a 3½ month time

span. The patient responded favorable to her therapy.

National treatment guidelines allow for this type of treatment for these types of injuries but not to the frequency and number of visits she received. Twenty-one therapy sessions over a 3½ month time span should have been sufficient treatment after surgery. There is no clinical justification for continued passive therapy and/or therapeutic exercises during the above time frame. In addition, during the rehabilitation, she should have been instructed in a proper Home Exercise Program and released to a home program. The office visits, special reports, needle electromyography-extremities, occupational therapy re-evaluation, nerve conduction with F wave and H reflex study were needed in order to properly evaluate her current condition, her response to treatment and to report her condition/work status to the appropriate authorities.

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