



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: Syzygy Associates, L.P. P. O. Box 25006 Ft. Worth, TX 76124	MDR Tracking No.: M5-07-0389-01 Previous No.: M4-06-3629-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: COMMERCIAL CASUALTY INSURANCE, Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "The treatment is well in line w/dx on unspec dies [sic] of lumbar."

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "There simply is insufficient medical documentation to substantiate the medical necessity for the abundance of treatments provided by requestor. The treatments are clearly excessive with no documentation of the medical necessity of the treatments or improvement in the Claimant's condition...."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. 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)
3-8-05 – 11-17-05	97003, 97110, 97032, 97530, A4556, 97002	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$0.00

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 Respondent denied several services as "213-This service does not appear to be related to injury and/or diagnosis." Per

DWC 24 agreement signed by the parties, the injury includes L3-4 and L4-5 SC Protrusions with Radicular Symptoms. The Respondent maintains its dispute on L5-S diagnoses. Neither the bills nor the medical records specify the levels treated. Therefore, all services from 3-8-05 – 11-17-05 were forwarded to the IRO for review.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

03-01-07

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

January 23, 2007

Amended Letter: February 5, 2007

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 #: M5-07-0389-01
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 he was trying to keep some trash from falling. This resulted in pain to his lower back. The patient has been treated with physical therapy modalities.

Requested Service(s)

97003- Occupational Therapy Re-Evaluation, 97110-Therapeutic exercises, 97032- Electrical Stimulation, 97530- Therapeutic activities, A4556- Electrodes and 97002- Physical Therapy Re-evaluation provided from 03/08/05 to 11/17/05.

Decision

It is determined that the 97003- Occupational Therapy Re-Evaluation, 97110-Therapeutic exercises, 97032- Electrical Stimulation, 97530- Therapeutic activities, A4556- Electrodes and 97002- Physical Therapy Re-evaluation provided from 03/08/05 to 11/17/05 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The general concepts concerning physical therapy for the treatment of lumbosacral strain syndrome are related to the goals, the duration, and the expected short and long term results. Passive modalities provide short term symptomatic relief of symptoms by relaxing acute episodes of muscle spasms. Active exercise programs should result in longer term prophylactic relief of symptoms by strengthening abdominal musculature, improving the mechanical support for paraspinal/musculature. The duration of the passive modalities should be in the range of 8-12 weeks with decreasing frequency as the active modalities result in more long-term relief. Durations longer than 8-12 weeks indicate that physical therapy is failing to achieve expected results, or symptomatic relief. Eight months of passive modalities is excessive and not medically necessary.

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, 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,

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

GBS:dm

Attachment

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M5-07-0389-01

Information Submitted by Requestor:

- Therapy Patient Discharge Summary
- Physical therapy notes
- Office Notes from Dr. Kjeldgaard
- Functional Capacity Evaluation
- Reports of MRIs of the lumbar spine
- Notes from Concentra Medical Center
- Report of examination by Dr. Hood
- Report of Required Medical Examination by Dr. Sedighi
- Claims
- Letter from attorneys
- Table of disputed services

Information Submitted by Respondent:

- Letter from attorneys
- Notes from Concentra Medical Center
- Physical Therapy progress notes
- Office notes from Dr. Kjeldgaard
- Report of MRI of the Lumbar Spine
- Report of required medical examination by Dr. Sedighi