

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-2835.M5**

MDR Tracking Number: M5-05-0084-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 3, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the medical necessity issues. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, therapeutic activities, direct (one-on-one) rendered from 9/8/03 through 9/26/03, office visits rendered from 12/22/03 through 1/21/04, 2/18/04, 3/12/04, 6/18/04, 7/16/04, therapeutic exercises from 12/22/03 through 1/4/04, range of motion measurements and report rendered on 10/15/03, physical performance test rendered on 10/27/03, 11/24/03, 12/22/03 and 1/21/04 **were found to be medically necessary**. The electrical stimulation and the manual therapy techniques **were not found to be medically necessary**. The respondent raised no other reasons for denying reimbursement of the office visits, therapeutic activities-direct one-on-one, therapeutic exercises, range of motion measurements, reports, physical performance test, electrical stimulation and manual therapy technique.

**ORDER**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 9/8/03 through 7/16/04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 1<sup>st</sup> day of November 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division

MQO/mqo

October 21, 2004

Hilda Baker  
TWCC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
TWCC #:  
MDR Tracking #: M5-05-0084-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

The reviewer notes that the patient's intake paperwork and patient's signature are spelled "\_\_\_". This appears to be a mistake on the TWCC 60. \_\_\_ was injured on \_\_\_ while working for \_\_\_. He was injured while he was loading a truck when he slipped off the ramp and fell to the ground. He presented to the office of Dr. A, DC. He

was treated with passive and active therapies, surgery, injections and rehabilitative services. MRI's of the lumbar spine, right knee (x2) and left hip were performed. A lumbar CT and discogram was performed. Neurodiagnostic testing revealed a possible radiculopathy. He was evaluated by Dr. P, DO, Dr. M, MD, Dr. Ma, MD and Dr. T, DC. The patient was assigned an 11% IR with MMI on 7/16/04. The latest DD examination by Dr. G, MD indicated the patient to not be at MMI as of 4/30/04.

Records were received from the requestor/treating doctor and respondent. The following represents the basic collection of records reviewed. It is not an exhaustive listing: The carrier submitted the following: Peer reviews by Dr. S, DC (10/2/03), \_\_\_ (1/6/04 and 7/21/04), RME by Dr. K, MD 1/19/04, 9/22/03 DD exam by Dr. Th, MD, 7/2/03 lumbar CT, 7/25/03 lumbar, right knee and left hip MRI, notes from DFW Pain Center from through 2/18/04, notes from Dr. P, DO from 8/19/03 through 4/27/04, notes from Dr. M, MD from 8/26/03 through 4/22/04, neurodiagnostic testing 8/13/03, operative report of 9/29/03, lumbar myelogram 9/12/03, notes from Dr. Ma 7/18/03, IR report by Dr. T, 1/16/04 lumbar discogram, FCE 2/18/04 and 3/31/04 right knee MRI.

The requestor/treating doctor submitted much of the above but also included the following: Work hardening notes from \_\_\_, DD exam by Dr. G, MD, note by Dr. M dated 2/26/04 indicating that an exacerbation had been suffered by the patient on 2/23/04.

#### DISPUTED SERVICES

Services under dispute include office visits, electrical stimulation, manual therapy and therapeutic activities from 9/8/03 through 7/16/04.

#### DECISION

The reviewer disagrees with the previous adverse determination regarding: **99213 and 97530** from 9/8/03 through 9/26/03; **99213** 12/22/03 through 1/21/04, 2/18/04, 3/12/04, 6/18/04, 7/16/04; **97110** from 12/22/03 through 1/4/04; **95851** 10/15/03; **97750** 10/27/03, 11/24/03, 12/22/03 and 1/21/04.

The reviewer agrees with the previous adverse determination regarding all remaining services under dispute.

#### BASIS FOR THE DECISION

The reviewer notes that the RME performed by Dr. K indicated that 'yes the length of care is appropriate' as of 1/19/04 in response to the question 'is the length of care appropriate?' The reviewer further states that the office visits were approved based upon the treating doctor's requirement to follow the patient through the course of care as per the standard of care. The Medical Disability Advisor by Dr. R, MD indicates that a lumbar disc injury can take

from four months to a year for resolution. The MDR indicates that the approved treatments fall within generally accepted protocols. The patient was returned to work and functionally improved during treatment as per Texas Labor Code 408.021. Therefore, the approved services were found to be medically necessary based on the above-mentioned principles. The reviewer notes that passive therapies were not necessary during the period of review.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,