

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

Type of Requestor: ( ) HCP ( ) IE ( ) IC	Response Timely Filed? (X) Yes ( ) No
Requestor's Name and Address <b>South Coast Spine and Rehab, P. A.</b> <b>620 Paredes Line Road</b> <b>Brownsville, TX 78521</b>	MDR Tracking No.: M5-05-2161-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Self Insurance Fund, Box 01	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

### PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
9-20-04	10-4-04	CPT code 97113	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9-16-04	10-5-04	CPT codes 99213-25, 97124, 97113, E1399	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

### PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 **not** prevail on the disputed medical necessity issues.

### PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for all of the services involved in this dispute and is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order. Reimbursement for the medical necessity issues is \$846.20.

Findings and Decision by:

_____ Donna Auby	_____ Typed Name	_____ 6-20-05 Date of Order
Authorized Signature	Typed Name	Date of Order

**PART V: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

**PART VI: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**



Specialty Independent Review Organization, Inc.

June 16, 2005

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

Patient: \_\_\_\_  
TWCC #:  
MDR Tracking #: M5-05-2161-01  
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

According to the records received and reviewed, Mr. \_\_\_ was working for \_\_\_ when he was injured in a work related accident. The patient was injured on \_\_\_. Mr. \_\_\_ was moving some signs weighing about 20lbs from an attic when his injured his low back. Later, the patient started having pain and numbness radiate down his legs. The patient was initially treated conservatively and later when the pain did not resolve with conservative management, the patient underwent a lumbar surgery in April of 2000. After the surgery, the patient underwent post-operative physical therapy. Subsequently Mr. \_\_\_ was treated by Dr. Howell who is the treating doctor at the time of this review. The patient had a prior lumbar disk surgery in 1997 unrelated to this incident.

#### RECORDS REVIEWED

Numerous treatment notes, diagnostic tests, staffing notes, evaluations, and other documentation were reviewed for this file. Specific records identified include but are not limited to the following: Medical Dispute Resolution Paperwork, TWCC-60, EOB's from the Insurance Carrier, IRO Summary from Parker & Associates, IR report by Dr. Pisharodi, DD report by Dr. Pettorino, Report from Rehabcorp, RME report from Dr. Loyez, Reports from Dr. Kramer, Report from Dr. Roberts, Records from Dr. Howell and First Rio Valley Medical, Medical Dispute Resolution Letter from South Coast Spine & Rehab Center, Records from Valley Regional Medical Center and Reports from Progressive Diagnostic Imaging.

#### DISPUTED SERVICES

Disputed services include the following: 99213 Office Visits, 97124 Massage Therapy, 97113 Aquatic Therapy and E-1399 DME from 9/16/04 through 10/5/04.

## DECISION

The reviewer agrees with the previous adverse decision regarding 97113 for all dates of service under review.

The reviewer disagrees with the previous adverse decision regarding 99213 for all dates of service under review.

The reviewer disagrees with the previous adverse decision regarding E-1399.

The reviewer disagrees with the previous adverse decision regarding 97124 for all dates of service under review.

## BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, Evidenced Based Medical Guidelines, Medicare Payment Policies, and Occupational Medicine Practice Guidelines. Also considered was the CPT codebook regarding description of services. In regards to the office visits, the treating doctor has the obligation to determine the medical status of a patient under his care and to evaluate the necessity for care and to administer care as medically necessary. These office visits would be necessary to evaluate Mr. \_\_\_ and make the appropriate management decisions. The massage therapy administered would be medically necessary as described above given the extent of Mr. \_\_\_'s injuries and the fact that he has a significant impairment rating from his condition and which may require additional care for flare-ups and exacerbations of his condition.

Mr. \_\_\_ does exceed the normative data as established by the MDA for his injuries, however given the fact that he has significant post-surgical injuries periodic care for exacerbations is acceptable. The medical necessity of performing aquatic therapy with Mr. \_\_\_ is not established in this particular case. The patient is several years post surgical/date of injury and should have already been instructed in a home exercise program. The reviewer indicates that he should not need the one on one supervision of an aquatic program this late after his injury date and surgery date. In addition, the contraindications to aquatic therapy were not adequately addressed. Mr. \_\_\_, according to the records received, has a heart condition and also has Hepatitis C. Both of these would be contraindications to aquatic therapy. These conditions could have possibly been cleared but were not addressed. Hepatitis is a serious infectious disease. There are also numerous mentions of the patient being referred to a chronic pain program. If a patient were a candidate for chronic pain, then the patient would not be a candidate for aquatic therapy. The home exercise program and durable medical equipment provided would be appropriate for the patient.

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,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director