

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> (X) Yes ( ) No
Requestor's Name and Address San Antonio Accident/Injury Care 401 W. Commerce, Suite 100 San Antonio, Texas 78207	MDR Tracking No.: M5-05-2306-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Box 29	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		
08-16-04	10-07-04	97116, 97110 and 97112	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input 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 **prevailed** on the disputed medical necessity issues.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount totaling \$4,033.02 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.

**Findings and Decision By:**

_____	_____	06-22-05
Authorized Signature	Typed Name	Date of Findings and Decision
<b>Ordered By:</b>	_____	_____
_____	_____	06-22-05
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 en español acerca de esta correspondencia, favor de llamar a 512-804-4812.**

June 17, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_  
EMPLOYEE: \_\_\_  
POLICY: M5-05-2306-01  
CLIENT TRACKING NUMBER: M5-05-2306-01 5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above-mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

**Records Received:**

Records from the State of Texas

Notification of IRO Assignment dated 5/31/05  
Medical dispute resolution request/response dated 4/25/05  
Explanation of review

Records from San Antonio Accident and Injury Care

Information request from Medical Review Institute of America dated 5/31/05  
Letter of dispute for non-payment of services for IRO review dated 3/17/05  
Letter from \_\_\_ \_\_\_ dated 9/26/04

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Photocopy of box that patient was lifting  
Letter from John Rheiner, MD undated  
Follow-up note dated 10/4/04  
Follow-up note dated 9/15/04  
Operative report dated 9/7/04  
Follow-up note dated 8/31/04  
Follow-up note dated 8/9/04  
Report of functional capacity evaluation dated 9/7/04  
Nerve conduction study report dated 7/20/04  
P.T. Exercise flow sheet dated 8/16/04 - 10/25/04  
Daily treatment log dated 8/16/04 - 10/7/04

Records from Dean G. Pappas and Associates

Letter from Dean G. Pappas & Associates to Medical Review Institute of America dated 6/6/05  
Information request from Medical Review Institute of America dated 5/31/05  
Independent medical evaluation from Timothy Fahey, DC dated 8/11/04  
Fax cover sheet dated 3/15/05  
MRI of lumbar spine report dated 6/16/04  
Initial consultation note dated 7/19/04  
Nerve conduction study report dated 7/20/04  
Reconsideration letter dated 8/6/04  
Follow-up note dated 8/9/04  
Follow-up note dated 8/31/04  
Follow-up note dated 9/15/04  
Follow-up note dated 10/4/04  
Report of functional capacity evaluation dated 9/7/04  
P.T. Exercise flow sheet dated 8/16/04 - 10/28/04  
Operative report dated 9/7/04  
Records from Texas Medclinic dated 6/23/04  
Daily treatment log dated 8/18/04 - 10/28/04

**Summary of Treatment/Case History:**

Treatment in dispute is for dates of service 8-16-04 thru and including 10-7-04. History is reported as \_\_\_, who was a teacher, fell over a student at work. Ms. \_\_\_ has had both X-ray and MRI with positive and supportive findings supportive of reported injury. Report on MRI dated 6/16/2004 include findings stated by Dr. Kevin Legendre as a broad based posterior 2mm annular disk bulge pressing onto the thecal sac and extending laterally on each side contributing to the narrowing of neural foramen bilaterally. Also noted is evidence of a left posterolateral annular tear seen on the T2 weighted sagittal images. The patient has received conservative care consisting of rehabilitative physical type therapies such as neuro rebuilding exercise, lifting and strengthening exercises and spinal realignment to reduce pressure onto the spinal components such as the disk and nerves which was delivered as chiropractic care. This patient has also to this date received epidural injection to help

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manage her perceived pain syndrome. The question for this review is regarding if #97110, #97112, and #97116 are medically necessary.

**Questions for Review:**

1. Items in dispute: Gait training - #97116, therapeutic exercises - #97110 and neuromuscular re-education - #97112. Denied for medical necessity with code U medical necessity without a peer review.

**Explanation of Findings:**

Review of physical therapy notes and notes regarding aquatic therapy reveal treatments #97116, #97112, and #97110 to be medically necessary and not in overuse regarding the injury. MRI reports show moderate broad-based disk injury. The treatment received is in requirement and expected for this type of spinal injury. Between the dates of 8-16-04 and 10-7-04 less than 20 visits were noted. Disk injury as noted on the MRI dated on 6-16-2004 reported a broad based 2mm annular disc bulge that was pressing up against the thecal sac ( the wrapping around the spinal cord) that spanned laterally to contribute to the narrowing of the neural foramen (the hole where the nerve structures exit the spine) bilaterally (both sides of the spine). During the time of physical therapy to include aquatic therapy, patient reported progress showed improvement. Disk bulges that impinge upon the thecal sac and resulting in the narrowing of the neural foramen are best addressed first with conservative care including aquatics, which offers non-weight bearing rehabilitative exercise. Treatment for this size bulge can typically and realistically utilize several months of care with varying outcomes.

**Conclusion/Decision to Certify:**

All dates of service for codes #97110, #97112, and #97116 are medically necessary.

**References Used in Support of Decision:**

Rehabilitation of the spine - lieberman  
Medline plus

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The physician providing this review is board certified in chiropractic medicine. The reviewer also holds additional certifications in Acupuncture and Orthopedics. The reviewer is a member of their state chiropractic association and is certified to provide reviews for the workers compensation commission as a designated doctor, RME and IME. The reviewer has been in active practice since 1998. MRloA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, patient and the TWCC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by

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state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRloA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRloA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRloA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRloA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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