

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC		Response Timely Filed? (X) Yes () No	
Requestor's Name and Address Julio Fajardo DC 2121 N. Main Street Fort Worth TX 76106		MDR Tracking No.: M5-05-2411-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address Rep Box # 54 Texas Mutual Insurance		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		
6-9-04	8-19-04	97140, 97110, A4595, and 97535	<input checked="" 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. The amount due from the carrier is \$1,281.70 (this amount does not include the DOP amount for the A4595 tens supply).

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-8-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 99080-73 billed on 6-17-04 was denied as "F, TD – work status report was not properly completed or was submitted in excess of the filing requirements." Since the requestor did not submit a copy of the TWCC-73 for review, no reimbursement recommended.

Code 99080-73 billed on 8-19-04 was denied as "F, TK – Rule 133.1 requires the submission of legible supporting documentation, therefore, reimbursement is denied." Since the requestor did not submit a copy of the TWCC-73 for review, no reimbursement recommended.

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 \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$1,281.70 plus DOP amount, plus all accrued interest due at the time of payment to the Requestor within 20 days of receipt of this Order.

Ordered by:

8-2-05

Authorized Signature

Typed Name

Date

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

YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

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

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date:	07/22/2005
Injured Employee:	
MDR #:	M5-05-2411-01
TWCC #:	
MCMC Certification #:	5294

REQUESTED SERVICES:

97140 manual therapy technique, 97110 therapeutic exercises, A4595 electrical stimulator supplies, 97535 self care management training.

DECISION: Reversed

MCMC llc (MCMC) is an Independent Review Organization (IRO) that has been selected by The Texas Workers' Compensation Commission (TWCC) to render a recommendation regarding the medical necessity of the above disputed service.

Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 07/22/2005 concerning the medical necessity of the above referenced requested service, hereby finds the following:

The denial of the services performed during the dates of service 06/09/2004-08/19/2004 is reversed.

CLINICAL HISTORY:

Records indicate that the above captioned individual was injured as the result of a work related injury that allegedly occurred on _____. The history reveals that the above captioned individual was lifting 30-foot long iron pipes onto some type of machinery. An incident was noted in which the injured individual noted felt immediate sharp pain. The injured individual presented to the office of the AP on 05/18/2004 at which time a course of passive care was initiated. On 06/10/2004, an MRI was performed which revealed a broad based disc herniation/protrusion at L5/S1 with some possible neural encroachment. A physical performance evaluation dated 06/15/2004 revealed significant functional deficits. Outcome assessment tools revealed various interruptions of activities of daily living as well as possible depression and/or anxiety. The injured individual participated in a litany of care inclusive of active and passive therapy, injections, medication management and chiropractic management.

RATIONALE:

The above captioned individual was injured on _____ and presented to the office of the AP on 05/18/2004 at which time a 30-day course of passive therapy was initiated. After this 30-day course of passive therapy a course of active therapy was

initiated. This course of care, including duration, is consistent with standards of care and practice within the chiropractic profession inclusive of those listed above. Furthermore, an MRI dated 06/10/2004 revealed a broad disc protrusion at L5/S1 with some possible neural impingement. However, the injured individual was not an obvious surgical candidate at that juncture, and the medical necessity for the initiation active care was established, especially in light of this significant complicating factor. Furthermore, a physical performance evaluation performed on 06/15/2004 revealed that the injured individual was performing at a light/medium physical demand category, which did not match favorably with his job-required physical demand category of very heavy. Lastly, daily notes and other documentation reveal that the injured individual positively benefited from the initial course of passive care as well as the initial course of active care further establishing the medical necessity of care from 06/09/2004-08/19/2004 including the items in dispute listed above.

REFERENCES:

References utilized in this review include but are not limited to the ACEOM Guidelines, Health Care Guidelines by Milliman and Robertson Volume 7, North American Spine Society Guidelines, Agency for Health Care Policy, Texas Medical Fee Guidelines and Research (AHCPR), and Procedural Utilization Guidelines.

RECORDS REVIEWED:

- TWCC Notification of IRO Assignment dated 06/09/05
- TWCC MR-117 dated 05/09/05
- TWCC-60
- MCMC Ilc: IRO Medical Dispute Resolution M5 Retrospective Medical Necessity dated 07/12/05
- MCMC Ilc: Notification letter dated 07/06/05
- Margaret Ojeda, TWCC: Order For Payment Independent Review Organization Fee dated 06/21/05
- Health Builders Chiropractic, P.A.: Check dated 06/17/05
- Texas Injury Clinic, Kevin Strathdee, D.C.: Interim Work Hardening-Physical Performance Evaluation dated 10/22/04
- Ved Aggarwal, M.D.: Procedure Notes dated 08/25/04, 07/29/04, 06/30/04
- Julio Fajardo, D.C.: Daily Notes dated 08/19/04, 07/16/04, 07/14/04, 07/12/04, 07/08/04, 07/07/04, 07/05/04, 07/02/04, 06/28/04, 06/25/04, 06/23/04, 06/21/04, 06/11/04, 06/09/04 and 06/07/04
- Ved Aggarwal, M.D.: Follow Up Examination dated 08/12/04
- Julio Fajardo, D.C.: Reports dated 08/03/04, 06/17/04
- Texas Injury Clinic, Mark Williams, D.C.: Functional Capacity Evaluation dated 07/20/04
- Ved Aggarwal, M.D.: History and Physical dated 06/24/04
- Texas Injury Clinic, Mark Williams, D.C.: Physical Performance Evaluation dated 06/15/04
- Nicholas Iwasko, M.D.: MRI of the lumbar spine dated 06/10/04
- Texas Mutual Insurance Company: Explanation of Benefits for services incurred 06/09/04 through 07/16/04
- Texas Injury Clinic: Lumbosacral-Rehabilitation Protocol dated 06/01/04 through 07/16/04
- Kevin Cowens, Sr., M.D.: Page 2 of an NCV/EMG test
- Texas Mutual Insurance Company letter of 07/20/05
- Texas Injury Clinic Daily Note of 05/19/04
- TWCC Work Status Report of 04/20/04
- Texas Injury Clinic Daily Note of 06/04/04
- MRI Group Radiology Report of 06/10/04
- Texas Injury Clinic Eval of 06/15/04
- Texas Injury Clinic Daily Note of 06/28/04
- Procedure note of Dr. Aggarwal of 06/30/04

- Texas Injury Clinic Daily Note of 07/02/04
- Texas Injury Clinic Daily Note of 07/14/04
- Texas Injury Clinic Daily Note of 07/16/04
- Texas Injury Clinic FCE of 07/20/04
- IME report of Dr. McCarty of 08/02/04
- Texas Injury Clinic Daily Note of 08/19/04

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this

22nd day of July 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____