



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 and Fee Issue

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: GABRIEL GUTIERREZ PO BOX 229 KATY TX 77492-0229	MDR Tracking No.: M5-05-2757-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: LIBERTY MUTUAL INSURANCE BOX 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 package, EOBs, CMS-1500s.
 Position Summary: The treatment provided to Ms ___ was reasonable and medically necessary consistent with the concepts of medical necessity as per the Texas Labor Code.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response.
 Position Summary: Refund requested but not received for WH on dates of service 8-24-04 to 8-26-04 and 8-30-04 based on peer review.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-20-04 to 10-11-04	97545-WH-CA and 97546-WH-CA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$11,476.00
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

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 Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues. The amount due from the insurance carrier for the medical necessity issues is \$11,476.00.

Per Rule 134.202, the first two hours shall be billed and reimbursed as one unit under 97545 with appropriate modifiers. Each additional hour shall be billed under 97546 with appropriate modifiers. Reimbursement is \$64.00/hour.

- 97545-WH-CA – recommend reimbursement of \$128.00 x 25 days = \$3,200.00
- 97545-WH-CA – for dates of service 8-24-04 to 8-26-04 and 8-30-04, the carrier paid \$75.00 each day.
Recommend additional reimbursement of \$53.00 x 4 days = \$212.00.
- 97546-WH-CA – recommend reimbursement of \$320.00 (5 hrs) x 22 days = \$7,040.00
- 97546-WH-CA – recommend reimbursement of \$256.00 (4 hrs) x 1 day = \$256.00
- 97546-WH-CA – recommend reimbursement of \$384.00 (6 hrs) x 2 days = \$768.00
\$11,476.00

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 8-30-05, the requestor withdrew 97750-FC for date of service 8-20-04; therefore, no review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of \$11,476.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Findings and Decision by:

Medical Dispute Officer

10-13-05

Authorized Signature

Typed Name

Date

Ordered by:

Associate Director

10-13-05

Authorized Signature

Typed Name

Date

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.



**PROFESSIONAL
ASSOCIATES**

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:	
IRO CASE NUMBER:	M5-05-2757-01
NAME OF REQUESTOR:	Gabriel Gutierrez, D.C.
NAME OF PROVIDER:	Gabriel Gutierrez, D.C.
REVIEWED BY:	Board Certified in Chiropractics
IRO CERTIFICATION NO:	IRO 5288
DATE OF REPORT:	08/12/05

Dear Dr. Gutierrez:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for Texas Workers' Compensation Commission (TWCC) to randomly assign cases to IROs, TWCC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this

review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Chiropractics and is currently listed on the TWCC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An initial injury report dated ___ from Todd Bear, D.C.

X-rays of the lumbar spine performed on 10/31/02 and interpreted by Tom Clayton, M.D.

An MRI of the lumbar spine performed on 12/05/02 and interpreted by Edward Knudson, M.D.

An NCV study of the lower extremity performed on 12/19/02 and interpreted by Eddie Sassoon, M.D.

A DSEP/NCV study of the lower extremity performed on 12/19/02 and interpreted by Dr. Sassoon

An ultrasound of the thoracic and lumbar spines, as well as the bilateral sacroiliac joint dated 12/19/02 and interpreted by Roberto Rivera, M.D.

A consultation with Rex Marco, M.D. dated 02/19/03

An operative report dated 09/25/03 from Dr. Marco

A Designated Doctor Evaluation dated 04/05/04 from Triet Huynh, M.D.

A letter "To Whom It May Concern" dated 04/21/04 from Dr. Bear

A response letter from Dr. Huynh dated 07/07/04

A progress note from Dr. Bear dated 07/12/04

A vocational assessment report dated 08/04/04 from Phillip Roddy, M.S., C.R.C.

A mental health assessment dated 08/12/04 from Monie Smith, M.A., L.M.F.T.

A Functional Capacity Evaluation (FCE) dated 08/20/04 with Gabriel Gutierrez, D.C.

An assessment for work hardening dated 08/20/04 from Dr. Gutierrez

A weekly work hardening report for the weeks of 08/23/04 through 08/30/04 from Dr. Gutierrez

Additional weekly work hardening reports from 09/15/04 through 10/11/04 from Dr. Gutierrez

A preauthorization request from Dr. Gutierrez dated 12/02/04

A preauthorization notice from Liberty Mutual dated 11/05/04

A notification of Maximum Improvement/First Impairment Income Benefit Payment Notice dated 11/11/04

A letter "To Whom It May Concern" dated 11/29/04 from Dr. Bear

A Required Medical Evaluation (RME) dated 12/01/04 from Anthony S. Melillo, M.D.

Clinical History Summarized:

On ____, Dr. Bear diagnosed the claimant with lumbalgia with a suspected lumbar disc herniation. Conservative treatment for four to six weeks and an MRI of the lumbar spine were recommended. An MRI of the lumbar spine dated 12/05/02 revealed a moderately large disc herniation at L5-S1 to the left of the midline and a moderate diffuse, mainly central, herniation at L4-L5. The claimant underwent a posterior spinal fusion and instrumentation from L5 to S1, with a compressive foraminotomy on the left side at L5-S1 with discectomy and placement of interbody grafts with right iliac crest bone graft on 09/25/03 by Dr. Marco. On 04/05/04, Dr. Huynh placed the claimant at Maximum Medical Improvement (MMI) on 04/05/04 and assigned the claimant a 20% whole person impairment rating. The claimant underwent an FCE on 08/20/04 with Dr. Gutierrez and a work hardening program was recommended. The claimant attended the work hardening program from 08/20/04 through 10/11/04 with Dr. Gutierrez. Liberty Mutual provided a preauthorization notice dated 11/05/04 denying work hardening starting on 10/27/04. In an RME performed by Dr. Melillo on 12/01/04, the claimant was felt to have chronic low back pain status post a two level lumbar fusion, left leg sciatica, and chronic pain syndrome with failed back surgery syndrome. It was felt the claimant could return to work with restrictions outlined by her FCE and it was possible the claimant might need to have her hardware removed in the future.

Disputed Services:

The work hardening program from 08/20/04 through 10/11/04

Decision:

I disagree with the insurance carrier as I feel that the work hardening program from 08/20/04 through 10/11/04 was reasonable and necessary.

Rationale/Basis for Decision:

The question remains as to whether the treatment provided to the claimant in the work hardening program satisfies the qualifications of Section 408.021 (31 of the Texas Labor Code), which only substantiates the need for care which (1) cures or relieves the effects naturally resulting from a compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or regain employment. Based upon a review of the supplied documentation, the claimant's condition appeared to improve at a reasonable pace under the work hardening program

performed by Dr. Gutierrez. Documentation demonstrated the fact that the claimant was able to become more functional, thereby demonstrating the ability to lift more weight each week under the work hardening program. Therefore, it would qualify for substantiation for the need of care under the Texas Labor Code 408.021. Promoting recovery of the claimant's condition and enhancing the ability of the claimant to return to employment. Therefore, the work hardening program from 08/20/04 through 10/11/04 should be considered medically necessary.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 twenty (20) calendar days** of your receipt of this decision (28 Texas Administrative Code 148.3).

This decision is deemed received by you **five (5) calendar days** after it was mailed and the first working day after the date this decision was placed in the carrier representative's box (28 Texas Administrative Code 102.5 (d)). A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to TWCC via facsimile or U.S. Postal Service on 08/12/05 from the office of Professional Associates.

Sincerely,
Lisa Christian
Secretary/General Counsel