



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 Dispute

#### PART I: GENERAL INFORMATION

**Type of Requestor:** (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:

South Coast Spine and Rehab, P. A.  
620 Paredes Line Road  
Brownsville, TX 78521

MDR Tracking No.: M5-05-2842-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Texas Workers Compensation Solutions, Box 19

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. The requestor states that the request is made in the form, format and manner prescribed by the Commission, per Rule 133.308.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The bills were denied as not reasonable or necessary to treat the compensable injury per carrier's peer advisor.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-20-04 – 10-13-04	CPT codes 99213, 99214, 97035, 97113, 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	-0-

#### 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 did not **prevail** on the majority of the disputed medical necessity issues.

#### PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

**PART VII: DIVISION DECISION**

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 not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby

9-16-05

Authorized Signature

Typed Name

Date of Order

**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.**

September 8, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_\_

EMPLOYEE: \_\_\_\_

POLICY: M5-05-2842-01

CLIENT TRACKING NUMBER: M5-05-2842-01 5278

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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:**

FROM THE STATE:

Notification of IRO assignment dated 8/11/05 1 page

Texas Workers Compensation Commission form dated 8/11/05 1 page

Medical dispute resolution request/response 2 pages

Provider form 1 page

Table of disputes services 1 page

Explanation of benefits from IMO dated 9/20/04 1 page

Explanation of benefits from IMO dated 9/29/04 1 page

Reconsideration explanation of benefits from IMO dated 10/4/04 1 page

Reconsideration explanation of benefits from IMO dated 10/7/04 1 page

Reconsideration explanation of benefits from IMO dated 10/13/04 1 page

FROM SOUTH COAST SPINE & REHAB CTR:

Final request for medical dispute resolution dated 8/12/05 15 pages

Initial evaluation dated 12/2/02 11 pages

Re-evaluation narrative dated 9/20/04 5 pages

Consultation notes dated 9/29/04 1 page

MRI of lumbar spine dated 9/22/04 1 page

Office visit notes dated 10/4/04 6 pages

Office visit notes dated 10/7/04 6 pages

Office visit notes dated 10/13/04 6 pages

Work status report dated 9/20/04 1 page

Initial examination report dated 9/21/04 4 pages

Follow up notes dated 10/26/04 3 pages

FROM TEXAS WORKERS COMP SOLUTIONS:

Letter from Edwards Claims Administration dated 9/1/05 1 page

Peer review dated 10/8/04 2 pages

Medical dispute resolution request response 1 page

Provider form 1 page

Table of disputed services 2 pages

**Summary of Treatment/Case History:**

This patient felt a “pop” in her low back after getting out of a car. She has had chiropractic treatment in 2002, and again in 2004 for 31 sessions. MRI showed 3mm disc protrusion at L4-5 only.

PT was 2 years out from the patient’s alleged back injury of \_\_\_\_\_. She already underwent PT in 12/02. There was no indication to initiate and continue with passive modalities such as ultrasound, massage, and aquatic therapy in 9/04 and 10/04 per ACOEM guidelines.

**Questions for Review:**

1. ITEMS(S) IN DISPUTE: Were office visits (#99213 and #99214), ultrasound (#97035), aquatic therapy (#97113), and massage (#97124) medically necessary from 9/20/04 to 10/13/04?

**Conclusion/Decision to Not Certify:**

1. ITEMS(S) IN DISPUTE: Were office visits (#99213 and #99214), ultrasound (#97035), aquatic therapy (#97113), and massage (#97124) medically necessary from 9/20/04 to 10/13/04?

The decision is to not certify office visits or PT 2 years after the patient’s lumbar strain. The patient should have been promoted to a home exercise program by 2003. See above for rationale. No treatment in 2004 would be reasonable, necessary or related to the alleged injury of \_\_\_\_\_.

**Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:**

ACOEM guidelines Chapter 12 indicates: “insufficient scientific testing exists to determine the effectiveness of these therapies”.

**References Used in Support of Decision:**

ACOEM Guidelines Chapter 12

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The physician who performed this review is board certified in Physical Medicine & Rehabilitation and Pain Medicine. This reviewer is a member of the American Academy of Physical Medicine and Rehabilitation, The American Academy of Electrodiagnostic Medicine, the American Medical Association, the Texas Medical Association, the American Academy of Pain Medicine and the American Academy of Musculoskeletal Medicine. This reviewer has been in active practice since 1995.

MRIOA 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 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 MRIOA 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 MRIOA 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 MRIOA 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 MRIOA 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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