



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:	MDR Tracking No.: M5-05-2858-01
Allied Multicare Centers 415 Lake Air Drive Waco, Texas 76710	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
TX Mutual Insurance Company, Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "The treatment and diagnostic testing provided to the injured worker was necessary, reasonable according to TWCC treatment guidelines, and referred by the injured worker's treating doctor."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form and Explanations of Benefits. The position summary states, "The requestor billed \$4,405.39. Texas Mutual paid \$0.00. The requestor believes it is entitled to an addition \$4,405.39."

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)
6-30-04 – 8-6-04	CPT codes 97110, 97112 and 98940	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,181.91
6-30-04 – 8-6-04	CPT codes 97124, 99213, 97530, 95831	<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. The amount due the requestor for the items denied for medical necessity is \$2,181.91.

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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement in the amount of \$2,181.91. 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 and Order by:

9-22-05

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.



Specialty Independent Review Organization, Inc.

August 15, 2005

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

Patient: _____
TWCC #: _____
MDR Tracking #: M5-05-2858-01
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

___ was injured on ___ while working for _____. He measures 5'10" and weighs approximately 226 lbs. The records indicate that he fell from a height of approximately 7 feet landing on his feet. He noted immediate lumbar spine pain. He reported to the company doctor; however, these initial records were not provided by any party to this dispute. He had been treated by William Blair, MD for approximately 6 months. Dr. Blair placed the patient at MMI with a 5% IR on 5/19/04 which is the day after he was seen by the designated doctor, Thomas Leonard who had indicated the patient to not be at MMI on 5/18/04. He presented to the office of AMC on 6/15/04. The initial report indicates that the patient had PT for five months with no improvement. Complicating factors of high blood pressure and obesity are noted. The doctor recommends continued PT for 3 x 4, home exercise protocols and passive therapies. The pain scale was rated as a 6/10. The records indicate that he was returned to limited work on 7/27/04.

RECORDS REVIEWED

Records were received from the treating doctor/requestor and from the respondent. Records from the TD/Requestor include the following: 6/16/04 evaluation by Allied Multicare Center (AMC), 6/27/04 subsequent medical report of AMC, 6/21/04 consult by Adam Borowski, MD, 1/8/04 thoracic MRI, 1/8/04 radiology reports by Scott and White, 1/20/04 cervical MRI, neurodiagnostic testing of 5/7/04, TWCC 69 report by William Blair, Jr. MD 5/19/04, 9/1/04 DD clarification letter, 7/27/04 FCE, 5/18/04 DD exam by Thomas Leonard, MD and Daily notes from 6/9/04 through 8/6/04.

Records from the respondent include some of the above in addition to the following: 8/5/05 letter by LaTreace Giles, RN, Bone scan of 3/3/04, 3/8/04 note by William Blair, MD, updated DD report by Thomas Leonard of 6/9/04, 6/15/04 initial narrative by AMC, handwritten note from Texas Institute of Health and a 7/27/04 subsequent medical narrative by AMC.

DISPUTED SERVICES

Disputed services include the following: 97124, 99213, 97110, 97112, 97530, 98940 and 95831 from 6/30/04 through 8/6/04.

DECISION

The reviewer disagrees with the previous adverse determination regarding codes 97110, 97112 and 98940 in the date range under review.

The reviewer agrees with the previous adverse determination regarding all remaining services.

BASIS FOR THE DECISION

The reviewer indicates that on the first look at this file the reviewers' inclination was that the provider had provided services that had already been attempted by the previous providers. However, the respondent did not provide these records indicating exactly what types of active therapy had been tried before. The patient's pain scale was reduced, his functionality was increased and he was returned to work at the termination of approximately 2 months of care. These are all hallmarks of medically necessary treatment as per TLC §408.021. The reviewer acknowledges the respondents letter of 8/5/05 by Nurse Giles which indicates that this person had a multitude of therapy by the treating doctors. However, it was apparent that the patient only received improvement during the treatment of AMC.

Studies indicate that chronic lower back pain will generally obtain benefit from rehabilitative programs. Manipulation has also been proven to be effective in chronic lower back pain. It is unknown whether the manipulation or the rehabilitation helped the patient to improve. It is possible that the combination of these therapies was effective.

REFERENCES

Van Tulder, et al Conservative treatment of acute and chronic nonspecific low back pain: a systematic review of randomized controlled trials of the most common interventions. Spine 1997; 22:2128-2156.

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