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 Dispute

PART I: GENERAL INFORMATION

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

Requestor's Name and Address: Horizon Health C/O Bose Consulting, LLC P O BOX 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-2995-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"treatment for the claimant was medically reasonable and necessary. We are requesting reimbursement for all disputed dates of services".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No position summary available in file.

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)
3-7-05 to 5-4-05	99212, 97110, 97112 and 97140	☒ Yes ☐ No	$7,010.85

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $7,010.85 per Rule 134.202(c)(1).

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1)

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 entitled to reimbursement in the amount of $7,010.85. 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:

		09-16-05
Authorized Signature	Typed Name	Date of Findings and Decision

Order by:

		09-16-05
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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-05-2995-01
Name of Patient:	___
Name of URA/Payer:	Horizon Health c/o Bose Consulting
Name of Provider: (ER, Hospital, or Other Facility)	Horizon Health
Name of Physician: (Treating or Requesting)	Carrie Schwartz, DC

August 31, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation

CLINICAL HISTORY
Items received for review included:
* Position Statement – Bose Consulting, LLC
* MRI Reports – Kevin Legendre, MD
* MRI Reports – Bob Maxcey, MD
* EMG/NCV Reports – Jeff Hamilton, DC
* Designated Doctor Reports – Gilbert Mayorga Jr., MD
* RME Reports – E. Floyd Robinson, MD
* IME Reports – James Hood, MD
* ESI Reports – K. Bobby Pervez, MD
* Orthopedic Reports – Jeffery Reuben, MD
* FCE Reports – Scott Herrel, DC
* Treating Doctor's Notes & Reports – Carrie Schwartz, DC
* Billing Statements & EOBs – Cambridge,

Available information suggests that this patient reports experiencing an occupational injury on ___ involving his hand, lower back and tail bone. He was taken to the emergency room where he received x-rays. The patient later presented to a chiropractor at Horizon Health in Houston, Texas and began treatment with active and passive physical therapy modalities. EMG was performed by another chiropractor suggesting no objective lumbar radiculopathy but indicating left S1 nerve root irritation. Lumbar MRI is performed confirming fractured but non-displaced coccyx and multilevel disc degeneration with L5/S1 facet hypertrophy. Left hand MRI suggests a 4mm metallic fragment near the second metacarpal without fracture or dislocation. The patient is referred for orthopedic assessment on 11/28/04 suggesting discogenic lumbar pain with orders to continue physical therapy and to undergo epidural steroid injections. The patient appears to undergo a series of ESIs with a pain management physician from 12/22/04 to 05/19/05 with recommendations to continue post injection physical therapy. The patient is seen for designated doctor evaluation on 01/31/05 and is found status post coccyx fracture, lumbosacral sprain, lumbar disc bulging and sprain of the wrist/hand that has not achieved MMI. Recommendations are made to complete ESI series with post-injection therapy, have FCE performed and progress to work hardening / work conditioning program. An IME is requested by carrier on 04/01/05 by an orthopedic surgeon suggesting that the patient is a candidate for CT myelogram and potential surgical correction. The patient is continued with post injection therapy modalities at chiropractic office. FCE does appear to be performed by another chiropractor on 04/05/05, but apparently for hand assessment only. The patient is seen for another RME by request of carrier on 05/18/05 suggesting the ESI series should be completed before MMI is determined.

REQUESTED SERVICE(S)
Determine medical necessity for office visits 99212, therapeutic exercises 97110, neuromuscular reeducation 97112, and manual therapy 97140 for period in dispute 03/07/05 through 05/04/05.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
Medical necessity for these ongoing treatments and services (99212, 97110, 97112 and 97140), for the period in

dispute (03/27/05 to 05/04/05), **does appear reasonably supported** by documentation submitted for review. Designated doctor evaluation clearly indicates medical necessity for continued ESI interventions with post injection therapy. None of the evaluations requested by carrier appear to conflict with these recommendations. Carrier's explanation of review suggests denial per determination by peer review, IME or other medical review. No such "peer review" determination appears to have been obtained.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. J Man Manip Ther 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.