



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-05-3120-01
Fuqua Health and Rehab 11007A Fuqua Houston, TX 77089	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

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary stated, "

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

Documents included TWCC 60 form, Explanations of Benefits, medical documentation and CMS 1500's. No position summary was received.

#### 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)
1-4-05, 1-13-05, 3-12-05, 3-24-05, 4-4-05, 4-8-05, 4-16-05, 4-25-05, 5-2-05, 5-10-05, 5-18-05, 5-24-05, 5-31-05, 6-6-05, 6-15-05, 6-23-05, 6-28-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,142.40
1-4-05 – 6-28-05	CPT codes 99213 (except dates listed above), 97140, 97032, 97110, 97116, 97035	<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 \$1,142.40.

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

28 Texas Administrative Code Sec. 133.308 and 134.202.

**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 additional reimbursement in the amount of \$1,142.40. 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:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

9-27-05  
\_\_\_\_\_  
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.

AMENDED REPORT 9/23/2005

September 6, 2005

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

Patient: \_\_\_\_  
TWCC #: \_\_\_\_  
MDR Tracking #: M5-05-3120-01  
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 with a specialty in Rehabilitation. 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

Ms. \_\_\_\_ was injured on \_\_\_\_ while employed with the \_\_\_\_\_ as an EO III. The records indicate she was injured when she hurt her back and neck while stepping down off of heavy machinery. She measures 5'5" and weighs 226 lbs. according to the records. Her previous history is positive for HBP, C-section and gall bladder surgery. Family history is positive for cardiovascular issues. The patient has been through passive modalities, active therapeutics, medicinal management and pain management injections.

Her initial pain scale was a 9/10 with cervical and lumbar pain. As of 7/1/04 her pain scale was to a 7/10. On 8/3/04, her pain scale was a 6/10. As of 9/1/04, her pain scale reduced to a 5/10 where it remained through 10/4/04 when it reduced to a 4/10. As of 11/5/04, Dr. Mai's notes indicate she is at a 4/10. The notes indicate the patient complained of cold weather being an aggravating factor. The FCE of 11/18/04 indicates pain scales of a 7/10 in all areas. Her pain scales varied from between a 3 to a 5 for the remainder of treatment under review.

The FCE of 9/9/04 indicates an ability to perform light-medium work while the FCE of 11/18/04 a light PDL secondary to submaximal effort. The Oswestry of 11/19/04 is rated as a 26/50 while the Vernon Meier indicates a 29/50.

Neurodiagnostic testing by Dr. Nguyen indicates a left C6 radiculopathy. On 10/29/04, Dr. Rodriguez recommends further PT with a WH program to follow. Dr. Francis returned the patient to work on 11/17/04 without restriction. On 3/31/05 Dr. Ibarra, designated doctor, opined that the patient had not reached MMI.

## RECORDS REVIEWED

Records were received from the requestor/treating doctor and from the respondent. Records from the respondent include the following: 11/17/04 RME report by Robert Francis, DC, various TWCC 73's, various HICFA 1500's, multiple EOB's, 6/10/04 report by John Mai, DC, patient daily progress reports from Fuqua Health and Rehab PA from 6/17/04 through 7/22/05, various EOBs, 6/30/04 lumbar and cervical MRI, neurodiagnostic report by Thai Duc Nguyen, MD, 9/9/04 FCE report from Back, Neck and Sports Pain Relief Center, 10/29/04 report by Jose Rodriguez, MD, 11/30/04 ESI report with surgical records, 11/18/04 Functional Abilities Evaluation, 3/31/05 DD report by Bartolome Ibarra, MD, 4/30/05 report by Jeffrey Reuben, MD, 12/23/04 rehab screening summary, 5/17/05 ESI note by Dr. Reuben, reconsideration letters (undated) by Dr. Mai, 5/27/05 report by Dr. Reuben, 4/30/05 report by Dr. Reuben, 6/21/05 ESI report, 7/1/05 report by Dr. Reuben, 7/19/05 ESI note, 8/1/05 note by Dr. Reuben, script by Dr. Reuben for lumbar MRI and an 8/1/05 note by Dr. Reuben.

Records from the requestor/treating doctor include some of the above in addition to the following: 10/06/04-12/15/04 notes by Triet Huynh, MD, 8/18/04 note by Dr. Nguyen, 6/20/05 neurodiagnostic report by Eddie Sassoon, MD, physician's statement to the and 12/23/04 letter and medical questionnaire from Freddie Brown.

## DISPUTED SERVICES

The services under dispute include 97140, 97032, 97110, 97116, 99213 and 97035 from 01/04/05 through 06/28/05.

## DECISION

The reviewer disagrees with the previous adverse determination regarding code 99213 on the following dates: 1/4/05, 1/13/05, 3/12/05, 3/24/05, 4/4/05, 4/8/05, 4/16/05, 4/25/05, 5/2/05, 5/10/05, 5/18/05, 5/24/05, 5/31/05, 6/6/05, 6/15/05, 6/23/05 and 6/28/05.

The reviewer agrees with the previous adverse determination regarding all remaining services and dates under review.

## BASIS FOR THE DECISION

The reviewer indicates that the patient continued to improve via pain scales through approximately early December of 2004. There was no documented functional improvement provided in the records as there were no PPE's or FCE's provided by any party after 11/18/04. The TWCC 73's did not indicate the patient was returned to work at any point in the care under review. Therefore, as per TLC 408.021, the treatment provided was not medically necessary as it did not reduce pain, increase functionality or provide a return to or an ability to continue working.

Secondly, the usage of passive therapies at this stage of treatment, chronic or fifth stage, is not recommended by the Mercy Guidelines, the ACOEM guidelines, the Medical Disability Advisor or the Council of Physiological Therapeutics and Rehabilitation Guidelines. The 97110 codes were not documented with exercise sheets or written documentation of the one on one services provided by Dr. Mai. Gait training was not shown to be prudent at this stage, as the reviewer could not determine why this service was performed. The injury was more severe in the cervical spine and there was no evidence of problems with heel/toe walk or issues with proprioception.

The office visits are approved as there have been several recent SOAH decisions that a weekly office visit is medically necessary to track the patient's progress and ensure timely referrals. Therefore, the approximately weekly office visits are approved as medically necessary.

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