



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: SCD Back & Joint Clinic, Ltd. 200 E. 24 <sup>th</sup> Street, Suite B Bryan, Texas 77803	MDR Tracking No.:
	Claim No.: M5-05-3146-01
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire 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, CMS 1500s and explanations of benefits  
 POSITION SUMMARY: The carrier denied payment for certain medical services provided to the above captioned patient. It is our position that these services were reasonable, necessary and related to the compensable injury. Appeals and follow up with the carrier have failed to resolve the dispute.

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

DOCUMENTATION SUBMITTED: Response to TWCC-60 and explanations of benefits  
 POSITION SUMMARY: None submitted by Respondent

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-02-04 to 11-15-04	99213-25, 99213, 99214-25, 99211-25, 97012, 98940, 97124, A9150, 97024, A9300, G0283 and L0500	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		<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 **did not prevail** on the disputed medical necessity issues.

On 09-07-05 the requestor withdrew the fee issues.

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

28 Texas Administrative Code Sec. 133.308

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

Findings and Decision by:

10-06-05

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

\_\_\_\_\_  
Date of Findings and Decision

**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.**



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** September 28, 2005

**To The Attention Of:** DWC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-16091

**RE: Injured Worker:**  
**MDR Tracking #:** M5-05-3146-01  
**IRO Certificate #:** IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) at the Texas Department of Insurance has assigned the above referenced case to Forté for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, 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 was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Submitted by Requester:**

- Summary of care
- Daily notes
- Exercise sheets
- Narrative reports
- TWCC forms
- Designated doctor forms
- Required medical examination forms
- Referral doctor information and examinations
- Therapeutic activity notes
- Durable medical equipment documentation

### **Submitted by Respondent:**

- Letter from the carrier
- Case adjuster timeline sheet
- Designated doctor report
- FCE reports

### **Clinical History**

According to the supplied documentation, the claimant sustained an injury on \_\_\_ when a co-worker fell on her and struck her in her legs. The claimant did not fall, but reported pain later that day. The claimant was seen by a company doctor and underwent some therapy and medical treatment. (There is little documentation for the initial care.) The claimant then changed treating doctors to John R. Wyatt, D.C. and began treating on 1/22/04. Dr. Wyatt diagnosed the claimant with a thoracic sprain/strain, muscle spasm and myofascial pain syndrome. Passive and active therapies were begun. The claimant was referred to Randall R. Light, M.D. for a neurological evaluation. Dr. Light diagnosed the patient with thoracic musculoskeletal pain and to continue conservative care. An MRI was performed on 2/3/04 which revealed mild degenerative changes with no spinal cord or nerve root compression. A designated doctor examination was performed by Milton E. Kirkwood, D.O. on 3/25/04. The claimant was determined not to be at maximum medical improvement. A required medical examination was performed on 4/2/04 with Hue W. Ratliff, M.D. Dr. Ratliff diagnosed the claimant with a strain on the right side of the thoracic area. He reported the claimant was at maximum medical improvement. Active and passive therapy continued through the dates of service in question. Some of the documentation supplied by the carrier reveals an additional work injury that occurred on or around \_\_\_\_\_ and treatment beyond was unrelated to the dates of service in question and was not reviewed.

### **Requested Service(s)**

Office Visits (99213-25; 99213; 99214-25; 99211-25), mechanical traction (97012), chiropractic manipulative treatment (98940), massage therapy (97124), durable medical equipment (A9150) (Biofreeze #28), diathermy (97024), durable medical equipment (A9300) (TB exercise ball # 24 and TB Gymnic ball instruction videos durable medical equipment # 23), manual electrical stimulation (G0283) and durable medical equipment (L0500) (criss cross ortho lumbar support durable medical equipment # 08) for dates of service 9/2/04 to 11/15/04

### **Decision**

I agree with the insurance carrier that the services were not medically necessary.

### **Rationale/Basis for Decision**

According to the documentation supplied by the provider, the claimant sustained an injury on \_\_\_ as a result of a work injury. The claimant was treated initially by a company doctor and later changed to Dr. Wyatt for further care. The designated doctor and required medical examination in this case both agreed that the claimant sustained a thoracic sprain. Without complications, an 8-12 week trial of conservative therapy would appear to be within a reasonable and medically necessary timeframe for care in this claimant's case. The documentation supported that the claimant had been well trained in the exercises that would help continue to improve her condition and help her to maintain employment. The documentation in question, according to the dates of service, are approximately 10 months post injury. Therapy rendered between 9/2/04 through 11/15/04 is not considered reasonable or medically necessary in relation to the compensable injury dated \_\_\_\_\_).

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to DWC via facsimile or U.S. Postal Service from the office of the IRO on this 28<sup>th</sup> day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder