



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: George Cole, D.O./Wellness Center 2300 Bell Street, Suite 20 Amarillo, Texas 79106	MDR Tracking No.: M5-05-3236-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Church Mutual Insurance Company Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC package, CMS 1500s, explanations of benefits and medical documentation  
 POSITION SUMMARY: No position summary submitted

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

DOCUMENTATION SUBMITTED: Response to DWC package, copy of peer review, explanations of benefits  
 POSITION SUMMARY: "There simply is no documentation to substantiate the medical necessity for the treatments provided by Requestor. In conclusion, the Requestor should not be entitled to any reimbursement for the disputed treatments or services".

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-23-05 to 06-15-05	64475-59, J1885, 90788 and 99213	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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.

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

**Findings and Decision by:**

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

11-17-05

\_\_\_\_\_  
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.**

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-05-3236-01
Name of Patient:	
Name of URA/Payer:	George M. Cole, DC
Name of Provider: (ER, Hospital, or Other Facility)	Wellness Center
Name of Physician: (Treating or Requesting)	George M. Cole, DC

November 14, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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 the Division of Workers' Compensation 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: Division of Workers' Compensation

## CLINICAL HISTORY

Records submitted for review included:

- MRIs of the lumbar spine 10/6/04 and 10/14/05 reports;
- Peer review by Richard Shirley, MD dated 5/12/05;
- Pulmonary angiogram 2/26/05;
- Family Orthopedics progress notes (8/17/05, 7/13/05, 6/16/05, 4/12/05, 5/3/05, 3/22/05, 3/17/05, 3/2/05); and
- Family Orthopedics Initial Examination dated 2/23/05, 2/16/05.

49-year-old male status post work related injury to the low back on \_\_\_\_\_. He received extensive pain management including injections and therapies.

## REQUESTED SERVICE(S)

Medical necessity of injection, lumbar or sacral, single level (64475-59), injection, ketorolac tromethamine, per 15mg (J1885), Intramuscular injection of antibiotic (90788), and office visit (99213) from dates of service 5/23/05 through 6/15/05.

## DECISION

Uphold denial.

## RATIONALE/BASIS FOR DECISION

Considering this patient's extensive treatment history and length of treatment up to 5/2005, continuation of treatment as described above is not warranted. Continuing unidisciplinary treatment of chronic pain is not supported by the current peer review literature. This decision is according to Dr. JJP Patil Rehabilitation Medicine: Principles and Practice eds JD Delisa, BM Gans and JK King Physical Medicine & Rehabilitation ed. Randall L. Baddom pivotal work in this area.

### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

### YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 14<sup>th</sup> day of November 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell