



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:

**South Coast Spine and Rehabilitation PA**  
**620 Paredes Line Rd**  
**Brownsville TX 78521**

MDR Tracking No.: M5-05-3314-01

Claim No.:

Injured Worker's  
Name:

Respondent's Name and Address:

**TML Intergovernmental Risk Pool Box 19**

Date of Injury:

Employer's Name:

Insurance Carrier's  
No.:

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

DWC-60 package. Position summary: We are requesting a medical dispute resolution by an Independent Review Organization.

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

Response to DWC-60 package. Position summary: The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-4-04 to 8-19-04	97032, 97124, 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.

Based on review of the disputed issues within the request, the Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

Rule 134.202 (b) states that system participants shall apply the Medicare program reimbursement coding, billing, and reporting payment policies in effect on the date a service is provided. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from the fee guidelines in effect on the date of service.

The requestor billed code 97139-SS on 8-9-04. This modifier is invalid after 8-1-03; therefore, no review and no reimbursement recommended.

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

28 Texas Administrative Code Sec. 133.308, 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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

**Findings and Decision by:**

Medical Dispute Officer

11-21-05

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

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

\_\_\_\_\_  
Date

**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.**

# IRO America Inc.

An Independent Review Organization  
7626 Parkview Circle  
Austin, TX 78731  
Phone: 512-346-5040  
Fax: 512-692-2924

November 8, 2005

TDI-DWC Medical Dispute Resolution  
Fax: (512) 804-4868

Patient:  
TDI-DWC #:  
MDR Tracking #: M5-05-3314-01  
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including: notes from South Coast Spine & Rehab Center, Cervical and Thoracic MRI, Cervical CT, Cervical – Thoracic – Lumbar X-Rays, Impairment Rating and office notes from Gilbert Meadows MD, operative report from Tim Chowdhury MD, peer review from Brian Buck MD, notes from Donald Nowlin MD.

## CLINICAL HISTORY

This Patient was employed by the \_\_\_\_\_, and stated he was injured on the job on \_\_\_\_\_. The Patient stated that he was the acting lieutenant and responded to a fire at a local country club where the building housing the golf carts was on fire. He stated he was wearing about 60 lbs of gear and squatted down to fight the fire, when he felt pain in his neck, mid back and low back. He continued to complete his job and when the fire was out, he reported his injuries to his supervisor.

## DISPUTED SERVICE(S)

Under dispute is retrospective medical necessity of electrical stimulation (97032), massage (97124), and office visit (99213) from 8/4/2004 to 8/19/2004.

## DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance carrier.

## RATIONALE/BASIS FOR THE DECISION

The date of injury in this case is \_\_\_ and the operative report is dated September 3, 2002. The rationale of continued use of passive modalities such as electrical stimulation and massage and office visits to complete these services are contradictory to the *Texas Workers' Compensation Spinal Treatment Guideline §134.1001* and the *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. At this point this injury is considered chronic and most guidelines would support that no passive treatment is recommended for chronic conditions to prevent the deleterious onset of physician dependence, somatization, continued chronicity, illness behavior, and de-conditioning all of which are adverse and lead to over utilization. Therefore, these services are considered unreasonable and medically unnecessary.

### Screening Criteria

1. Specific:

- A. Texas Workers' Compensation Spinal Treatment Guideline §134.1001
- B. Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

## CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**