



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: Santiago Guajardo, D.C. 3303 W. FM 1960 Suite 360 Houston, Texas 77068	MDR Tracking No.: M5-06-0031-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Ace American Box 15	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC-60 dispute package  
POSITION SUMMARY: Per the table of disputed services "Treatment medically necessary for extent of injury (as per medical documentation/referrals & diagnostics). Patient entitled to care under Tx. Labor Code/Sect. 408.021

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

DOCUMENTATION SUBMITTED: Response to DWC-60  
POSITION SUMMARY: No position summary 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)
12-03-04 to 12-30-04	97110, 97140 and 97139	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,618.03

#### 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 **prevailed** on the disputed medical necessity issues.

#### 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 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 entitled to additional reimbursement in the amount of \$2,618.03. 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.

Ordered by:

12-15-05

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

\_\_\_\_\_  
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]

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

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

**REVISED 11/15/05**

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0031-01
Name of Patient:	
Name of URA/Payer:	Santiago Guajardo, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Santiago Guajardo, DC

October 24, 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 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

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Dr. Guajardo (DC), consulting doctors' reports from Drs. Pervez (MD), Weiss, (MD), Varon, (MD), Shanti (MD), Kobza (DO) and Lamarra (DPM). MRI reports (right wrist & right ankle) 09/22/04, electrodiagnostic studies 10/08/04, sequential FCE reports.

Ms. \_\_\_\_, a 36-year-old female, injured her right ankle and right wrist while working as a delivery driver for \_\_\_\_\_. She was leaving the store carrying several boxes when she tripped in a floor depression, twisting her right ankle. She fell and landed on her outstretched right wrist and hand. She consulted with Dr. Guarjardo, a chiropractor, who placed her on a conservative treatment regime consisting of passive modalities progressing to exercises and manual therapy for a treating diagnosis of internal ankle derangement, wrist sprain/strain, motion restriction and muscle spasms.

She was seen for a podiatric consult with Dr. Lamarra who treated her with an intra-articular steroid injection and gave her a special boot. Diagnostically, she had x-rays and MRIs performed of both the ankle and wrist, all were negative. She had electrodiagnostic studies performed on 10/8/04, these were again negative. A FCE on 9/8/04 indicated a light PDL below the waist and a sedentary PDL of both the waist, FCE on 12/15/04 showed a light PDL below the waist and a sedentary-light PDL above the waist. The patient continued at work without time loss as a result of her injury.

She was seen by hand specialist, Dr. Varon, who prescribed anti-inflammatories and continued physical therapy. She was seen by designated doctor on 12/28/04 who opined that she was not at MMI and that she should continue physical therapy with progression into work hardening program.

#### REQUESTED SERVICE(S)

Medical necessity of therapeutic exercises (97110), manual therapy (97140), unlisted therapeutic procedure (97139) 12/3/04 through 12/30/04

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

*The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.*

The patient sustained injuries to her ankle and wrist. Physical findings and diagnoses were consistent amongst all consulting providers with the treating doctor. Recommendations for physical therapy and continuation of physical therapy through the disputed timeframe were consistent between all consulting and treating physicians. The documentation supports that the procedures were performed, and that functional improvement with pain reduction was obtained with the treatment provided.

Although the number of units of therapeutic application exceeded Medicare guidelines, they were justified given the fact that there were two separate areas of complaint that needed to be addressed.

Medical necessity has been established in this case.

#### **References:**

1/ Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

2/ Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

(a) Chapter 8, pp. 115-129.

(b) Frequency and duration of care.

3/ Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

4/. Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

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 15<sup>th</sup> day of November 2005.

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

Printed Name of IRO Employee: Cindy Mitchell