



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: Pain & Recovery Clinic 6660 Airline Drive Houston, Texas 77076 | MDR Tracking No.: M5-06-0107-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Liberty Insurance Corporation Box 28 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package
 POSITION SUMMARY: "All treatments and services were rendered in good faith to treat the injured employee's compensable injuries. They were also rendered in conjunction with invasive pain management" from the table of disputed services.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 package
 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) |
|----------------------|-------------------------------|--|--------------------------------|
| 11-23-04 to 01-03-05 | 99211, 97112, 97110 and 97140 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> | \$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:

11-29-05

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.



Specialty Independent Review Organization, Inc.

Amended 11/18/2005

October 27, 2005

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

Patient:
DWC #:
MDR Tracking #: M5-06-0107-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC 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 Medical Doctor with a specialty in Pain Management and Anesthesia. The reviewer is on the DWC 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

The patient sustained an injury while lifting a package. He has complained of low back pain with radiation down the legs. He has had multiple injections including epidural steroid injections and SI Joint and facet injections. He has had an MRI and an EMG. He has taken several medications: Norco, Robaxin, Fiorcet, and a topical gel. He has also had a course of physical therapy.

Records Reviewed:

Records from Doctor: Pain Institute of Texas-Notes, Initial Evaluation; Pain Institute of Texas-Letters and rebuttals; Pain and Recovery Clinic-Initial Evaluation and Progress Notes; Pain Institute of Texas-Follow-up note; Pain and Recovery Clinic of North Houston-Progress Notes

Records from Carrier: Letter from Liberty Mutual; Letters from Professional Reviews, Inc; Letter from John Harney, MD; Discography and Operative Reports; Houston Community Hospital-Operative Reports

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of 99212-OV, 97112-neuromuscular reeducation, 97110-therapeutic exercises and 97140-manual therapy from 11/23/2004 through 1/3/2005.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The Neuromuscular Re-Education CPT coding is part of Post stroke rehabilitation and is NOT appropriate here. (see VA/DOD practice guideline on Post stroke rehabilitation in the primary care setting)

Manual therapy and therapeutic exercises are indicated only in the 8 week period immediately following injury as per the NASS guideline: Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists. North American Spine Society. Unremitting low back pain. LaGrange (IL): North American Spine Society (NASS): 2000.

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 the reviewing provider has no known conflicts of interest between that 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.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the via facsimile, U.S. Postal Service or both on this 18th day of November 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli