



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:
 Rafael Loya, D.C.
 2973 Bingle Road
 Houston, Texas 77055

MDR Tracking No.: M5-06-0173-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
 Service Lloyds Insurance Company
 Box 42

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 "necessary medical treatment"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 package

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)
10-04-04 to 11-18-04	99212, 99211, 97110 and 97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$571.06
10-11-04	97035, 97124 and 97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-09-04, 11-17-04 and 11-18-04	97112	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
01-11-05 to 05-04-05	97112, 99211, 97110, 97530 and 99212	<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 **majority** of disputed medical necessity issues.

Based on review of the disputed issues within the request, the Medical Review 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.

On 09-30-2005, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 dates of service 10-11-04 and 03-02-05 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 99080-73 is a required report which is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rules 129.5 and 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 reimbursement in the amount of \$601.06. The Division finds that the requestor was the not prevailing party and is not entitled to a refund of the IRO fee. 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:

Authorized Signature

12-13-05

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:	M5-06-0173-01
Name of Patient:	
Name of URA/Payer:	Rafael Loya, DC
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Rafael Loya, DC

November 7, 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

ITEMS REVIEWED:

Notification of IRO Assignment – MDR Request Forms

Tables of Disputed Services

Corvel –EOBs and Explanations of Review

Medical Record Review – Forrest Lee Moses, DC

Harris & Harris – Service Lloyd's Insurance Co. position statements

PM&R Medical Review – Zvi Kalisky, MD

Designated Doctor Evaluation – Muntaz Ali, MD

Orthopedic Specialty Review – William Walters, MD

Medical Reports – Richard Francis, MD

FCE Reports – Bingle Crossing Chiropractic, Rafael Loya, DC

Medical Notes, Operative Reports – Ihsan Shanti, MD

Electro diagnostics Reports – Jeffery Hamilton, DC

MRI Reports - Kevin Legendre, MD

Chiropractic Daily Treatment Notes – Rafael Loya, DC

Available information suggests that this patient reports experiencing an occupational injury on ____ involving his lower back. The patient later presented to a chiropractor at the Bingle Crossing Chiropractic Clinic in Houston, Texas on approximately 08/03/04. The patient is diagnosed with lumbar neuritis / radiculitis, sprain / strain, and muscle spasm. No report of initial chiropractic or subsequent chiropractic examination is provided for review. Chiropractic treatment involved several weeks of passive therapy including ultrasound, electric stimulation, chiropractic manipulation, moist heat and massage. The patient was referred to Ihsan Shanti, MD for pain management, medications and injections on 08/04/04. MRI was performed 08/24/04 suggesting disc narrowing and degenerative changes with broad based disc protrusions at L3/4, L4/5 and L5/S1. The patient underwent EMG/NCV studies on 09/01/04 suggesting no evidence of radiculopathy, neuropathy or motor neuron disease. The patient was

seen for medical evaluation with Richard Francis, MD, on 10/12/04 suggesting annular tears of the L3/4, L4/5 and L5/S1 levels. Conservative measures are recommended to include strengthening and stretching exercises for a period of six weeks. Chiropractic FCE is performed 10/11/04 suggesting some range of motion and strength deficits. Chiropractic care appears to be modified to include both passive therapies and therapeutic exercises. Designated doctor evaluation is made 02/01/05 by Muntaz Ali, MD, suggesting that the patient has achieved MMI with 5% WP residual impairment due to injury.

REQUESTED SERVICE(S)

Determine medical necessity for therapeutic exercise (97110), office visits (99211, 99212), massage therapy (97124), electric stimulation (97032) neuromuscular reeducation (97112), ultrasound (97035) and therapeutic activities (97530) for the period in dispute 10/04/04 through 05/04/05.

DECISION

All dates of service involving (97124, 97035, 97032 and 97112) are not supported for medical necessity (for period in dispute 10/04/04 to 05/04/05). Services involving chiropractic management (99212 and 99211) and therapeutic exercise (97110 and 97530) are supported for period in dispute (10/04/04 to 12/31/04 only). All treatment in dispute from 01/01/05 to 05/04/05 is not supported for medical necessity.

RATIONALE/BASIS FOR DECISION

The medical necessity for ongoing passive modalities (97124, 97035 and 97032) are not supported by available documentation. Ongoing physical modalities of this nature suggest no further potential for resolution of symptoms and restoration of function at this late phase of treatment. In addition, neuromuscular reeducation (97112) is not necessarily a passive modality, but is essentially undocumented by DOP in available chiropractic reporting and is not specifically supported for medical necessity. There is, however, evidence to support chiropractic evaluation and management services (99211 and 99212). In addition, medical necessity is demonstrated and documented for therapeutic exercise (97110 and 97530) for this period in question. This ongoing treatment is also supported by FCE findings and the notes and orders of Richard Francis, MD, from 10/12/04. Treatment and exercise of this nature beyond six weeks duration is not

supported. Therefore, all treatment in dispute beyond 12/31/04 is not supported for medical necessity.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" *Journal of Family Practice*, Dec, 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4):182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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 8th day of November 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell