



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

| | |
|---|---------------------------------|
| Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier | |
| Requestor's Name and Address: Galaxy Health Care Centers, P.A. 17333 Spring Cypress Suite C Cypress, Texas 77429 | MDR Tracking No.: M5-06-0191-01 |
| | 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 dispute package
POSITION SUMMARY: Per the table of disputed services "Medically necessary"

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) |
|---|--|---|--------------------------------|
| 10-06-04 to 10-20-04 | 99213, 97032, 97035, 97140 and 97110 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1,299.07 |
| 09-22-04 to 10-04-04 and 10-25-04 to 12-17-04 | 99213, 97035, 97110, 97140, 97150, 97032 | <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 the disputed medical necessity issues.

Per Rule 133.308(e)(1) dates of service 09-17-04 was not timely filed and will not be a part of the review.

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 reimbursement in the amount of \$1,299.07. The Division finds that the requestor was not the 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:

12-22-05

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.



CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name:

Texas IRO #:

MDR #: M5-06-0191-01

Social Security #:

Treating Provider: Alexander Kurt Riley, D.C.

Review: Chart

State: TX

Review Data:

- Notification of IRO Assignment dated 10/18/05, 1 page.
- Receipt of Medical Dispute Resolution Request dated 10/18/05, 1 page.
- Medical Dispute Resolution Request/Response dated 9/19/05, 2 pages.
- Provider Federal Tax Identification Number and the License/Certification/Registration Number Request Forms, 3 pages.
- Table of Disputed Services Form dated 9/17/04, 9/22/04, 9/24/04, 9/27/04, 9/29/04, 10/1/04, 10/4/04, 10/6/04, 10/8/04, 10/11/04, 10/15/04, 10/18/04, 10/20/04, 10/22/04, 10/25/04, 10/27/04, 10/29/04, 11/1/04, 11/5/04, 11/19/04, 11/22/04, 11/24/04, 11/29/04, 12/1/04, 12/3/04, 12/10/04, 12/13/04, 12/15/04, 12/17/04, 9 pages.
- Explanation of Payments dated 9/22/04, 9/24/04, 9/27/04, 9/29/04, 10/1/04, 10/4/04, 10/6/04, 10/8/04, 10/11/04, 10/15/04, 10/18/04, 10/20/04, 10/25/04, 10/27/04, 10/29/04, 11/1/04, 11/5/04, 11/19/04, 11/24/04, 11/29/04, 12/01/04, 12/3/04, 12/10/04, 12/13/04, 12/15/04, 12/17/04, 26 pages.
- New Patient Evaluation Report dated 4/29/04, 4 pages.
- Preliminary Chiropractic Modality Review dated 5/28/04, 4 pages.
- Operative Report dated 7/19/04, 3 pages.
- Lumbar Spine MRI dated 9/29/04, 2 pages.
- Chest and Lumbar Spine X-Rays dated 11/3/04, 1 page.
- Lumbar Spine Epidural Steroid Injection Treatment (1st Series) dated 11/3/04, 2 pages.
- Preliminary Chiropractic Modality Review dated 11/16/04, 3 pages.
- Lumbar Spine Epidural Steroid Injection Treatment (2nd Series) dated 11/17/04, 2 pages.
- Chest and X-Rays dated 12/8/04, 1 page.
- Lumbar Spine Epidural Steroid Injection Treatment (3rd Series) dated 12/8/04, 2 pages.
- Required Medical Examination Report dated 12/27/04, 11 pages.
- Texas Worker's Compensation Work Status Report dated 12/27/04, 1 page.
- Treatment Notes dated 9/20/04, 9/22/04, 9/24/04, 9/27/04, 9/29/04, 10/1/04, 10/4/04, 10/6/04, 10/8/04, 10/11/04, 10/13/04, 10/15/04, 2 pages.
- Re-Examination Notes dated 10/4/04, 1 page.
- Treatment Notes dated 10/18/04, 10/20/04, 10/23/04, 10/25/04, 10/27/04, 10/29/04, 11/1/04, 11/5/04, 11/8/04, 11/10/04, 11/12/04, 11/15/04, 2 pages.
- Re-Examination Notes dated 11/1/04, 1 page.
- Treatment Notes dated 11/19/04, 11/22/04, 11/24/04, 11/29/04, 12/1/04, 12/3/04, 12/6/04, 12/10/04, 12/13/04, 12/15/04, 12/17/04, 12/20/04, 2 pages.
- Re-Examination Notes dated 12/6/04, 1 page.
- Correspondence dated 1/22/05, 3 pages.
- Position Statement dated 10/25/05, 2 pages.
- Assessment and Physical Examination Report dated 3/1/04, 4 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied office visits, ultrasound,

therapeutic exercises, manual therapy technique and therapeutic procedures, with dates of service of 9/22/04 through 12/17/04.

Determination: **REVERSED** – 6 treatments for dates of service of 10/6/04 through 10/20/04.
UPHELD – treatment for dates of service of 9/22/04 through 10/4/04 and 10/25/04 through 12/17/04.

Rationale:

Patient's age:

Gender: Male

Date of injury: ____

Mechanism injury: Lifting a pump out of a barrel above his head in a twisting position, and when he stepped off the pallet, he experienced a numb feeling in his low back, around his hips, and to his bilateral groin area; and he had low back pain.

Diagnoses: Low back pain with radiculopathy, disc herniations at L4-5 and L5-S1 and postoperative discectomy and foraminotomy.

While employed for _____, the claimant sustained an injury to his lower back. The claimant presented to the office of Dr. Riley complaining of lower back pain. Treatment interventions consisting of chiropractic spinal manipulation and passive physiotherapy modalities were initiated. An MRI of the lumbar spine, dated 4/19/2004, revealed a posterior disc extrusion at L4-5 and L5-S1 with spinal stenosis at the same levels. Electrodiagnostic studies of the lower extremities revealed findings suggestive of a bilateral L5-S1 radiculopathy. On 3/1/2004, the claimant was evaluated by Dr. Shanti. His recommendation was for physical therapy under the direction of Dr. Riley. On 4/29/2004, the claimant was referred to the office of Dr. Fogel, a spine surgeon, for an evaluation. His recommendation was for bilateral laminectomy and foraminotomy with partial discectomy at L4-5 and L5-S1. The claimant also received a course of epidural steroid injections. Due to a failure of conservative treatment to bring about a resolution of the claimant's condition, on 7/19/2004, the claimant underwent bilateral laminectomy and foraminotomy at L4-5 and L5-S1. On 8/9/2004, the claimant then began a course of post surgical rehabilitation under the direction of Dr. Riley. According to the Independent Medical Evaluation (IME), dated 12/27/2004, the claimant then came under the care of Dr. McDonnell, who recommended lumbar fusion surgery. According to the position statement letter dated 10/25/2005 from Dr. Riley, the claimant opted to continue with aggressive active rehabilitation to strengthen the region, instead of lumbar fusion surgery. On 11/3/2004, 11/17/2004 and 12/8/2004, the claimant underwent epidural steroid injections. Finally, on 12/27/2004, the claimant underwent a Required Medical Evaluation under the direction of Dr. Ratliff, an orthopedist. Dr Ratliff concluded that the treatment rendered to date, had been reasonable and necessary. He further indicated that the claimant would require fusion surgery of L5-S1. A clarification report was submitted dated 1/22/2005, from Dr. Ratliff. He indicated that no further chiropractic care or physical therapy was medically necessary. He outlined treatment recommendations should the claimant require fusion surgery. To date, the claimant has not required fusion surgery.

Treatments for dates of service 9/22/2004 through 12/17/2004, for a total 28 treatments, are in dispute. Based upon the Peer Review Report by Dr. Morgan, dated 5/28/2004, no chiropractic sessions were recommended beyond 4/23/04. However, Dr. Morgan was not aware of the surgical intervention to which this claimant submitted on 7/19/04, subsequent to his Peer Review Report. On 7/19/04, the claimant underwent a bilateral laminectomy and foraminotomy at L4-5 and L5-S1. Postoperative physical therapy was initiated three times per week by Dr. Riley on 8/9/04. According to the Official Disability Guidelines, 9th Edition, Work Loss Data Institute, 2004, pages 142 and 143, 10 visits of physical therapy over 8 weeks or up to 18 chiropractic treatments over 6 to 8 weeks can be considered appropriate with evidence of objective functional improvement. By 9/22/04, the claimant presumably received 18 postoperative therapy sessions (based upon three sessions per week since 8/9/04), however, according to the 10/25/2005 position statement letter, the claimant received five weeks of post surgical rehabilitation that was authorized by the insurance company. The documentation for these five weeks of service was not submitted for review. This letter further indicated that the claimant had an exacerbation on 9/13/2004. The type and nature this exacerbation was not available for review. Treatment notes beginning 9/20/2004 were available for review. There was no reference to the supposed 9/13/2004 exacerbation. There was a notation on the 10/6/2004 note, that the claimant had a "severe exacerbation" with an increase in pain. The claimant's pain level increased from 4 out of 10 to 8 out of 10 on the visual analogue scale. By 10/20/2004, the claimant's pain levels had reduced to 4 out of 10. The claimant's pain levels remained consistent through the remainder of treatment. Also of note, was that the claimant's pain levels were similar to those corresponding to the period which preceded the surgery.

The purpose of this review is to determine the medical necessity for treatments corresponding to the dates of service from 9/22/2004 through 12/17/2004. According to the Official Disability Guidelines, 9th Edition, Work Loss Data Institute, 2004, pages 142-143, 10 physical therapy visits over 8 weeks or up to 18 chiropractic visits over 6-8 weeks can be considered appropriate,

with evidence of objective functional improvement. As noted above, the claimant received five weeks of treatment. It appears from the treatment notes beginning 9/20/2004, that the claimant's pain levels were at 4 out of 10 on the visual analogue scale. Based on the submitted documentation, it appears that the claimant's condition had plateaued by 9/17/2004. The claimant was provided treatment that brought the claimant to a stable position of 4 out of 10 on the visual analogue scale. Additional treatment should have been performed within the context of a home-based exercise program. The notes indicate that the claimant had an exacerbation on 10/6/2004. Inasmuch as the Official Disability Guidelines do not address an exacerbation in a postoperative patient whose therapy has exceeded the recommendations set out therein, any determination as to additional treatment must rely on an alternative reference. Accordingly, based upon such claims of an exacerbation, Rehabilitation For The Postsurgical Patient would support a limited number of passive treatment interventions. Therefore, six (6) treatments for dates of service from 10/06/04 through 10/20/04 can be recommended. None of the treatments rendered between 9/22/04 and the onset of the exacerbation (i.e. 10/06/04) can be recommended, nor can any of the treatments rendered between 10/25/04 and 12/17/04 be recommended.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.
ACOEEM Guidelines, 2nd Edition, Chapters 6 and 12.
The Official Disability Guidelines, Ninth Edition, 2004.
Rehabilitation For The Postsurgical Orthopedic Patient, by Lisa Maxey and Jim Magnusson.

Physician Reviewers Specialty: Chiropractic

Physician Reviewers Qualifications: Texas licensed DC, and is also currently listed on the TDI/DWC list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.