



**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

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0237-01
Coastal Spine Medical Center 5327 S. McColl Rd. Edinburg, TX 78539	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Liberty Mutual Fire Insurance, Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include DWC-60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position Summary states, "Documentation submitted along with said requests demonstrated that services being requested were deemed medically necessary, as determined by Nurse Reviewer."

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

Documents include DWC-60 form and Explanations of Benefits. No position summary was received.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
9-28-04 – 12-2-04	CPT codes 99212, 97110, 97124, 97035	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby

12-12-05

Authorized Signature

Typed Name

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.**

November 29, 2005

TDI, Division of Workers' Compensation  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-06-0237-01  
DWC#:  
Injured Employee: \_\_\_\_  
DOI: \_\_\_\_  
SS#: \_\_\_\_  
IRO Certificate No.: IRO 5055

Dear Ms. \_\_\_\_:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the DWC Approved Doctor List.

#### 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,

Gilbert Prud'homme  
General Counsel  
GP:dd

## REVIEWER'S REPORT

M5-06-0237-01

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### Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Visit 12/02/04

Daily PT Notes 09/28/04 – 11/30/04

Information provided by Respondent:

Correspondence

Spine:

OR Report 03/04/03 – 10/26/04

Nerve Conduction Study 02/06/02

Radiology 12/12/01 – 07/07/04

### Clinical History:

Patient is a 41-year-old oil driller who, on \_\_\_\_, slipped and fell about 10 feet while working on a rig, landing onto his left ankle and lower back. The patient continued working despite the pain, but by the end of the day, he had severe pain and was walking with a pronounced limp. Since the injury, he has undergone several surgeries, including a lumbar laminectomy, fusion, and bone graft with insertion of instrumentation on 2/26/03, then a repeat lumbar laminectomy, fusion, removal of instrumentation and insertion of internal bone stimulator on 7/24/03. On 8/30/03, the patient underwent surgical repair, debridement and irrigation; on 9/30/03, he had a foreign body removed; and, a posterior ankle ligament repair was done on 4/03/04. Later, a follow-up MRI of the lumbar spine performed on 7/7/04 revealed disc dessication with annular disc bulge at L5-S1, and moderate bilateral facet joint arthrosis with bilateral encroachment along the lateral recesses. Therefore, and due to the patient's persistent symptomatology, a bilateral facet median branch block at L3, L4 and L5 was performed on 10/26/04, followed by post-injection therapy.

### Disputed Services:

Established patient office visits, levels II and IV (99212 and 99214), therapeutic exercises (97110), massage (97124) and ultrasound (97035) from dates of service 9/28/04 through 12/2/04.

### Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were not medically necessary in this case.

### Rationale:

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. Expectation of improvement in a patient's condition should be established based on success of treatment. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment.

In this case, however, there was no documentation of objective or functional improvement in this patient's condition, and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Rather, the records submitted contained outdated results of tests, diagnostics, and operative reports, and then "daily progress notes" for only the dates of service in dispute that utilized words with vague descriptions of the patient's status (eg., "limited lumbar flexion/extension" without specific values, and "decreased/increased pain" without quantifying the pain levels in any usable fashion), and lacking any specific examination that established a base line at the outset of care, (there was an examination report from 12/2/04, which was *after* the dates of service in dispute), or any reference to a home exercise program having been initiated. This resulted in a lack of objective, documented efficacy of care without supporting evidence to demonstrate continuing benefit. And, there was no basis to continue a therapy that was not providing significant benefit.

The records did not just lack any submitted documentation establishing medical necessity, they also failed to establish any over-all improvement in the functional status as it pertained to returning this patient to work. There was also no provided end-point for further treatment, and no notation for review that outlined plans to reduce treatment frequency and return the patient to work that would otherwise substantiate the need for these services.