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

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Cantu Chiro-Rehab Center P.O. Box 16684 Houston, TX 77222	MDR Tracking No.: M5-06-0501-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Indemnity Insurance Company, Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "These bills have incorrectly been denied."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response 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)
11-4-04 – 1-18-05	CPT code 97032 ($20.04 X 9 DOS + $20.34 X 3 DOS)	☒ Yes ☐ No	$241.38
11-4-04 – 1-18-05	CPT code 97110 ($35.91 X 64 units + $35.86 X 36 units)	☒ Yes ☐ No	$3,589.20
11-4-04 – 1-18-05	CPT code 97140 ($36.75 X 12 DOS+ $33.94 X 5 DOS)	☒ Yes ☐ No	$610.70
11-4-04 – 1-18-05	CPT code 97112 ($33.91 X 2 DOS)	☒ Yes ☐ No	$67.82
11-4-04 – 1-18-05	CPT code 99213	☒ Yes ☐ No	$65.00
	Grand Total		$4,574.10

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.

In accordance with Rule 133.308 (e) date of service 10-28-04 was not timely filed and will not be a part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor did prevail on the majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is $4,574.10.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

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 carrier must refund the amount of the IRO fee ($460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of $4,574.10. 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.

Findings and Decision and Order by:

	Donna Auby	2-1-06
Authorized Signature	Typed Name	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.

IRO America Inc.

An Independent Review Organization
7626 Parkview Circle
Austin, TX 78731
Phone: 512-346-5040
Fax: 512-692-2924

January 18, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:
TDI-DWC #:
MDR Tracking #: M5-06-0501-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care 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.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Medical records from Requestor, Respondent, Treating Doctor, Insurance Company, including but not limited to IRO request, Medical records from United Neurology, EMG/NCV report dated 7-15-2004 and 7-26-2004, MRI report cervical and lumbar spine 6-21-04 and 6-10-2004, referral slip to Dr Athari MD, Patient information sheets, Medical records from requestor, Reconsideration letters 4-07-2005 and 10-28-2005, Request for reconsideration letter 3-2-2005, Peer review Forte 7-19-2004 Dr. Michael Malizzo MD, Follow-up evaluation Work Conditioning & Management dated 12-23-04, 1-06-05, 1-11-05, 11-23-04, 10-12-04, 1-17-05, 11-10-04, Reports Bobby Pervez, MD 8-30-04, 10-25-04, Operative report Bobby Pervez, MD 9-30-

04, 19 pages of daily progress notes Cantu Chiro-Rehab Center date range 10-28-04 through 4-14-2004, Notice of IRO Assignment, TWCC-60, EOB's for associated dates, FCE dated 11-11-04.

CLINICAL HISTORY

The Patient apparently sustained a work related injury on ___, when she slipped on a wet floor and landed on her back, reportedly injuring her neck, mid-back and low back, developing numbness and tingling into the left lower extremity and bilateral hands. She was initially seen by Dr. Jiang on 5-11-04. She was referred for an MRI of the cervical and lumbar spine. MRI of the cervical spine revealed a disc bulge at C5-6. MRI of the lumbar spine reveled disc protrusions/herniations/bulges at L3-4, L4-5, and L5-S1. She was referred to Dr. Pervez, MD, who performed an Arthrogram. The Patient under went a fairly aggressive rehabilitation program under the supervision of Dr. Cantu.

DISPUTED SERVICE (S)

Under dispute is the medical necessity of 97032-ELECTRIC STIMULATION, 97110-THERAPEUTIC EXERCISE, 97140-MANUAL THERAPY, 97112-NEUROMUSCULAR REEDUCATION, 99213-OFFICE VISIT. Services denied by carrier for medical necessity. Services dates in dispute are 11-04-2004 through 1-18-2005.

DETERMINATION / DECISION

The Reviewer disagrees with the determination of the insurance carrier in this case.

RATIONALE / BASIS FOR DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services were medically necessary. EMG/NCV study performed on 7-15-2004 and 7-26-2004 and MRI study performed on 6-10-2004 and 6-21-2004 correlates with clinical symptoms and defines specific pathologies. Epidural injections were performed and provided relief, again, correlating the above and providing medical necessity. It is medically appropriate to undergo rehabilitation following epidural steroid injection. Services provided significant relief and progression. Additionally, other providers/records supported the medical necessity throughout care.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for

presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

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.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 18 day of January, 2006.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer