



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: Valley Spine Medical Center 5327 South McColl Road Pharr, Texas 78539	MDR Tracking No.: M5-06-0559-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute

POSITION SUMMARY: Per the table of disputed services "The care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "The carrier submits that the requestor has failed to establish that the medical treatment made the basis of the disputed charges for all other dates of service was reasonable and necessary".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-12-04 to 02-18-05	99205, 99080-73, 97035, 97124, G0283 and 97012	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
11-23-04 to 12-14-04	97140 (2 units @ \$63.46 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$317.30
	97110 (1 unit @ \$34.46 X 1 DOS)		\$34.46
	97110 (3 units @ \$103.38 X 3 DOS)		\$310.14
	99212 (\$44.16 X 4 DOS)		\$176.64
	99215 (1 DOS)		\$141.55
02-18-05	99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.98
12-04-04 & 02-18-05	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$30.00
TOTAL			\$1,087.07

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 **prevailed** on the **majority** of the disputed medical necessity issues.

The Requestor withdrew date of service 12-21-04 CPT code 90801 on 03-22-06, therefore, this date of service will not be part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202

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 \$1,087.07. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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:

05-18-06

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.

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

REVISION II - 5/16/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0559-01
Name of Patient:	
Name of URA/Payer:	Valley Spine Medical Center
Name of Provider: (ER, Hospital, or Other Facility)	Valley Spine Medical Center
Name of Physician: (Treating or Requesting)	Alex Flores, DC

April 17, 2006

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

REVISION II - 5/16/06

CLINICAL HISTORY

Items Reviewed:

Notification of IRO Assignment

MDR Request Response

Chiropractic Reports and Notes / Alex Flores, DC

Medical Orthopedic Reports and Notes / Pete Garcia, MD

TENS Unit / Conductive Garment Request / Pete Garcia, MD

FCE / Work Hardening Reports and Notes / Valley Spine and Medical Center

Orthopedic/Occupational Medicine Notes and Reports / Fred Perez, MD

Isometric Functional Testing / Back Inst. Of South Texas

Group Therapy Progress Notes / Janie Rodriguez, M.Ed. LPC

Physical Medicine Reports and Notes / Cynthia Garcia, MD

Medical Orthopedic Reports and Notes / Donald Vargas, MD

X-ray Reports / Rafath Quaraishi, MD

MRI Reports / Lauren Nguyen, MD

Peer Review Assessment / Jack Kern, MD

Pain Management Psychiatric Reports and Notes / Elisa Garza Sanchez, MD

Pain Management Notes, S. Texas Chronic Pain Inst. / Yolanda Herrera, M.Ed. LPC

Request for Benefits Review / Dispute Resolution Information Data Sheets

Designated Doctor Evaluation MMI/IR Reports / Enrique Linar, MD

Available information suggests that this patient reports experiencing an occupational injury on ___ involving the lumbar spine, left hip, right elbow and bilateral wrists which is said to have occurred as a result of a fall in a correctional facility. The patient presented initially to a Don Vargas, MD, who prescribes medication, injections and physical therapy. MRI obtained 06/07/04 suggests broad based disc bulge at L5/S1 without neural compromise. Bilateral diffuse lumbar spine facet disease and chronic degenerative change is also noted. The patient is referred for physical medicine assessment by a Cynthia Garcia, MD who also recommends physical therapy. The patient later presents for orthopedic assessment with Pete Garcia, MD on or about 11/12/04. The patient is found with lumbar sprain/strain, grade 2, non-specific lumbago, and muscle spasms. Additional physical therapy is ordered to include manipulation, EMS, traction, ultrasound, massage, cold packs and therapeutic exercise. Chiropractic initial assessment appears to be made on 11/17/04 including findings from Dr. Garcia's initial exam and confirming physical therapy orders with the addition of cryopacks, ADL instruction and OTC Biofreeze as a topical analgesic. Request appears to be made for 3x per week for 4 weeks. This treatment plan appears to continue through 02/18/05 when the patient appears to begin a work hardening program. The patient appears to undergo subsequent pain management evaluations and treatments with several providers including Dr. Perez, Dr. Chanraskharan, Dr. Sanchez and others.

Designated doctor evaluation is made 10/12/05 suggesting chronic degenerative facet disease and sacroillitis aggravated following work related injury. Elbow and wrist injuries are said to have healed without residual. The patient is found at MMI with 5% WP impairment from DRE lumbosacral category II.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99205, 99212, 99213, 99215), TWCC/DWC Reporting (99080-73), manual therapy (97140), massage (97124), electric stimulation (G0283), ultrasound (97035), mechanical traction (97012), therapeutic exercises (97110), and OTC Biofreeze (E1399) for period in dispute 11/12/04 through 02/18/05.

DECISION

Approve office visits (99212, 99213, 99215), TWCC/DWC Reporting (99080-73), manual therapy technique (97140), therapeutic exercises (97110) and Biofreeze (E1399).

Deny office visit (99205), TWCC/DWC Reporting (99080-73), ultrasound (97035), massage (97124), mechanical traction (97012), and electrical stimulation (G0283).

RATIONALE/BASIS FOR DECISION

Available documentation **does not support** the chiropractic services (99205 and 99080-73) performed on 11/12/04 only, as chiropractic initial exam does not appear to have occurred until 11/17/04.

Additional passive therapies (97035, 97124, 97012 and G0283) appear to be a duplication of passive therapy already performed by previous providers, and at 6 months post injury, these services do not appear to have any clinical potential for further restoration of function or resolution of chronic symptoms.

There **does appear to be reasonable documentation and clinical necessity demonstrated** for chiropractic services (99212, 99213, 99215), including work status report (99080-73) of 12/14/04 and 12/18/05, as these appear to be appropriate evaluation and management interactions during the period noted. Documentation also appears to reasonably support chiropractic services (97140, 97110 and E1399), as these services do not appear to have been previously provided and do appear to provide some measure of functional restoration or self care management for conditions noted.

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.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell