



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:	MDR Tracking No.: M5-06-0602-01
Health & Medical Practice Assoc 324 Nth 23 rd Street, Suite 201 Beaumont TX 77707	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Texas Mutual Insurance Box 54	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position summary: Medically necessary.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
6-17-05 to 8-31-05	97530, 97032, 97124	<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 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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Medical Dispute Officer

1-30-06

Authorized Signature

Typed Name

Date

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

Corrected January 25, 2006

January 24, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

IRO #:

M5-06-0602-01

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

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

1. Table of Disputed Services.
2. Explanation of Benefits from Texas Mutual Insurance Co., 6-17-05 through 8-31-05.
3. Report from L. Giles, RN, 12-30-05.
4. MRI of the right knee, 2-9-01.
5. Dictated report from S. Bourn, M.D., 2-14-01.
6. Lumbar MRI, 2-27-01.
7. DD Evaluation by Charles Clark, M.D., 11-20-02.
8. Operative report, 1-16-03.
9. Post-Myelogram CT of the lumbar spine, 1-16-03.
10. MRI of the right knee, 9-9-03.
11. Operative report, 2-25-04.
12. Operative report-Discogram, 6-21-04.
13. Post-Discogram CT lumbar spine, 6-21-04.
14. Operative report, 12-29-04.
15. Operative report, 1-3-05.
16. Discharge Summary, 1-6-05.

17. Physical Therapy report from Golden Triangle Physical Therapy, 3-22-05.
18. Medical Progress Notes, 6-17-05, 9-12-05, 10-12-05, 11-1-05, and 11-29-05.
19. Reports from Health and Medical Practice Associates, 6-17-05 through 9-9-05.
20. Orthopedic Evaluation by W. Francis, M.D., 8-16-05.
21. Documentation from the provider including Preface, Rehabilitation for the Postsurgical Orthopedic Patient, Operative reports and Prescriptions for physical therapy, House Bill 2600, TWCC rule 134.202, TWCC 408.021, Medicare part B Newsletter number 3-33, Medicare Physical Medicine and Rehabilitation, Physiotherapy Notes and Daily Notes from 6-17-05 through 8-12-05, Medical records for time frame of IRO, Health Information Claim Forms, EOB denials, other carrier EOB payments, and references.

CLINICAL HISTORY

___: The Patient sustained a right knee and low back injury after a trip and fall.

2-9-01: Right knee MRI revealed bone contusions involving the medial aspect of the patella and subcortical aspect of the medial tibial plateau, complex grade III tear within the posterior horn of the lateral meniscus, grade III horizontal cleavage tear involving the body of the lateral meniscus, and degenerative grade III tear along the free edge of the posterior horn of the medial meniscus.

2-14-01: The Patient was evaluated by Dr. Bourn. He reported knee pain and lateral leg symptoms. Symptoms occurred on 1-24-04 after tripping over a track. The Patient was taking Ibuprofen and Hydrocodone. Diagnosis was right knee lateral meniscus tear and right lower extremity radiculopathy. Dr. Bourn recommended a lumbar MRI.

2-27-01: Lumbar MRI revealed multi-level disc bulging and spondylosis, small focal disc displacement at L4-L5 and L5-S1, neural foraminal encroachment on the right at L3-L4 and L4-L5 with nerve root abutment at L4-L5 on the right.

11-20-02: DD Evaluation was performed by Charles Clark, M.D. This report indicated The Patient sustained a knee and back work related injury. The Patient had 3 epidural steroid injections in Houston. The Patient was not working. The Patient was using a cane and also wearing a back brace. The Patient was determined to be at maximum medical improvement and assigned 13% WPI.

1-16-03: Post-Myelogram CT demonstrated obliteration of the right lateral recess at L5-S1.

9-9-03: Right knee MRI revealed small amount of fluid within the joint space, complete peripheral destruction of the posterior horn of the lateral meniscus, and an abnormal signal involving the inferior margin of the posterior horn of the medial meniscus consistent with a partial tear.

2-25-04: Surgery was performed to include a right knee arthroscopic lateral meniscectomy, arthroplasty, ACL repair, complete synovectomy, and insertion of a pain pump catheter.

6-21-04: Lumbar discogram demonstrated a full thickness annular tear at L3-L4 and right posterior annular tear at L4-L5. Post-Discogram CT demonstrated a full thickness annular tear at L3-L4, large right-sided full thickness tear at L4-L5 with a disc herniation, and a partial thickness right lateral annular tear at L5-S1.

12-29-04: Decompression at L4-L5 and L5-S1 as well as a fusion from L3 to the sacrum was performed.

1-3-05: Anterior lumbar fusion was performed.

3-22-05: The Patient started aquatic therapy at the Golden Triangle Physical Therapy clinic.

6-17-05: Therapy was initiated at the Health and Medical Practice Association. The Patient reported a constant pulling sensation in his lumbar spine. Pain was consistent at a moderate level regardless of activity. Lumbar numerical pain scale was 4/10 with intermittent bilateral hip pain and stiffness. The Patient reported his pain was very manageable in his activities of daily living. Lumbar range of motion brought on an increase of symptomatology. There were overt signs of patient soreness and tenderness during palpation. Muscle spasms and guarding was evident. Positive orthopedic tests included Double Leg Raise, Goldwait's, and Kemp's. All tests were only positive on the right. Lumbar flexion was 38°, extension 22°, left lateral flexion 15°, right lateral flexion 20°, left SLR 50°, and right SLR 28°. Therapy included therapeutic activities, electrical stimulation, and massage therapy.

7-13-05: Re-evaluation was performed. The Patient reported bilateral low back pain. Lumbar range of motion was reduced with pain. Lumbar range of motion increased symptomatology. Palpation revealed tenderness in the lumbar paraspinal musculature. Spasms and muscle guarding were evident. Doubled Leg Raise, Goldwait's, and Kemp's were all positive bilaterally. Lumbar flexion was 41°, extension 22°, left lateral flexion 15°, right lateral flexion 20°, left SLR 50°, and right SLR 30°.

8-19-05: Orthopedic evaluation by William Francis, M.D. reported ongoing back pain and radiating symptoms into the hips and legs. He recommended aquatic therapy.

9-12-05: Progress Notes reported ongoing lumbar pain rated 4/10 with symptoms radiating down into the buttocks and hips bilaterally. Knee pain was also rated 4/10.

10-12-05: Progress note reports a numerical pain scale of 8/10 for both the lumbar pain and knee pain. Lumbar pain radiated down into the bilateral buttocks and right thigh. Edema was noted in the knee.

11-1-05: Progress note reports 'very severe' low back pain rated 9+/10 radiating down into the buttocks and legs (bilaterally).

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of 6-17-05 thru 8-31-05 therapeutic activities (97530), electrical stimulation (97032), and massage therapy (97124) for the dates 6/17/05 thru 8/31/05.

DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The items in dispute cannot be supported. This patient previously participated in aquatic therapy at the Golden Triangle Physical Therapy clinic; therefore, in order to justify any additional therapy, it is necessary to establish that the treatment was efficacious in a quantified and objectively measurable manner.

After reviewing the documentation supplied, there is a complete lack of subjective improvement to support care. In fact, on the initial evaluation dated 6-17-05, The Patient reported constant, moderate level back discomfort with intermittent bilateral hip pain and stiffness very manageable with activities of daily living. The Patient reported a numerical pain scale of 4/10. After three months of care (9-12-05), The Patient reported low back pain rated 4/10 with radiating symptoms into his hips. After four months of postoperative care (10-12-05), The Patient reported very severe low back pain radiating into his right posterior thigh rated 8/10. Knee pain was also reported as 8/10. After five months of postoperative care (11-1-05), The Patient reported a numerical pain scale of 9+/10 with symptoms radiating down his thigh and legs bilaterally. This documentation clearly indicates the treatment performed between 6-17-05 and 8-31-05 did not relieve the effects of the injury.

The documentation fails to demonstrate adequate objective/functional improvement despite the treatment performed. There is a lack of quantified objective improvement in regards to ROM, strength/endurance testing, orthopedic testing, or functional testing, and therefore the treatment failed to promote functional recovery.

The Patient is still not working; therefore, it does not appear the treatment enhanced the ability of The Patient to return to work.

Lastly, the electrical stimulation and massage can not be supported. Despite several randomized clinical trials on electrical stimulation, no consistent benefit has been shown on clinically relevant outcomes such as pain, functional status, or patient global assessment (Deyo, NEJM, 1990; Marchand, Pain, 1993; and Moore, Arch Phys Med Rehabil, 1997). The BMJ and QTF recommends that massage should be considered as a therapeutic option for chronic low back pain, particularly for relief of muscle spasms; however, as with all manual procedures, there is a point of diminishing return. Massage treatment should be time-limited. Numerous guidelines recommend against manual procedures such as massage greater than 8-10 weeks. The Patient was five months status post fusion when the therapy in dispute began. Additionally, The Patient had already participated in postoperative therapy. The Reviewer's assessments is the message therapy was not medically necessary.

Screening Criteria

1. Specific:

- Deyo, NEJM, 1990; Marchand, Pain, 1993; and Moore, Arch Phys Med Rehabil, 1997

2. 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 25th day of January 2005.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.



Dr. Roger Glenn Brown
President & Chief Resolutions Officer