



**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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0851-01
Jack P. Mitchell, D. C. P. O. Box 9159 Longview, TX 75608-9159	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Travelers Indemnity Company, Box 05	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, "The insurance carrier shall take final action on the medical bill as described in Rule 133.304 (b). Hopefully, the carrier will further understand our position and make payment in full promptly."

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

Documents include the DWC 60 response. Position summary states, "The rationale for our denial is based on peer review where the doctor determined that ongoing treatment is not medically necessary."

#### 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)
4-13-05 – 10-20-05	CPT code 97112	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.00
4-13-05 – 10-20-05	CPT code G0283 (\$13.61 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$68.05
4-13-05 – 10-20-05	CPT code 97012 (\$17.76 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$88.80
4-13-05 – 10-20-05	CPT code 98941 (\$43.00 X 5 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$215.00
4-13-05 – 10-20-05	HCPCS Code A4556	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.18
	<b>TOTAL</b>		<b>\$422.03</b>

#### 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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$422.03.

**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 \$422.03. 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

2-14-06

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.**



Specialty Independent Review Organization, Inc.

February 13, 2006

DWC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
DWC #:  
MDR Tracking #: M5-06-0851-01  
IRO #: 5284

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

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Chiropractor. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ was injured on \_\_\_ while working for Schulmberger Technology. The injury occurred when he picked up engine parts weighing approximately 50 lbs. These parts were lifted from the ground level to the level of the shoulder/head. MRI was performed on 10/30/01 indicating a broad based herniation at L1/2, L3/4 herniation with right sided neuro-foraminal narrowing and L5/S1 herniation. He was treated and released from care by Jack Mitchell, DC. He was assigned a 5% WP impairment by the designated doctor on or about 11/14/02. On 6/8/04 Luther Bratcher, DC performed an RME evaluation. Dr. Bratcher indicates "we all can expect some exacerbations in Mr. \_\_\_ working career" and "it appears some type of therapy to ease muscle spasms and a spinal manipulation has and will obtain a significant reduction in spinal symptoms." On 3/3/05, Mark Carlson, DC indicates manipulation is not effective for chronic lower back pain based upon AHCPR guidelines and chapter 12 of the ACOEM Guidelines.

#### RECORDS REVIEWED

Records were received and reviewed from the requestor and from the respondent. Records from the requestor include the following: 1/30/06 letter from Dr. Mitchell, request for recon of Dec. 2005, Corvel denial, 3/3/05 report of Mark Carlson, DC, 6/8/04 RME by Luther Bratcher, DC, 10/30/01 lumbar MRI, radiographic report of 10/6/01, SOAP notes from 07/26/01 through 10/20/05, TWCC 69 and report of 11/14/02, various TWCC 73's and patient intake information.

Records from the respondent include the following: All records provided by the respondent were the same as the records provided by the requestor.

## DISPUTED SERVICES

Services under dispute include 97112, G0283, 97012, 98941 and A4556 from 4/13/05 through 10/20/05.

## DECISION

The reviewer disagrees with the previous adverse determination regarding all services under dispute.

## BASIS FOR THE DECISION

The reviewer notes that secondary to Mr. \_\_\_'s permanent impairment he is entitled to future medical benefits in compliance with Texas Labor Code 408.021. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment. According to the notes, Mr. \_\_\_'s treatments meet all three of these requirements. For example, in the daily note of 4/13/05, Mr. \_\_\_ complains of considerable lower back pain due to a lot of bending at work. He notes a significant reduction in lower back pain after the treatments rendered. He returns to work and is able to work for 3 ½ months without treatment with Dr. Mitchell. As of the 7/27, he presents with lower back pain radiating down the leg to the ankle. After treatment he notes reduction in lower back pain and no further pain in the leg.

On 9/29/05, Mr. \_\_\_ presents with lower back and leg pain after prolonged bending at work. After treatment he has a 75% reduction in pain. He presents the following day noting he still has a 'catching in certain positions' yielding lower back pain (limited ADL) without leg pain. He is provided with interferential pads for personal use.

On 10/20/05, the patient presented for an exacerbation of lower back pain secondary to extended bending at an oil field service station. Again the patient receives significant relief from treatment and is able to return to his job at full duty.

Dr. Mitchell's treatments that were provided to this patient helped to relieve the gentleman's suffering from the work related accident, which apparently resulted in a multi-level degenerative disc disease with herniations of the lumbar spine. As per the natural history of a lumbar disc injury, Mr. \_\_\_ presents with lumbar pain and radicular symptoms on an occasional basis. These symptoms were correctly treated by Dr. Mitchell and the patient was placed on a PRN basis of treatment.

## REFERENCES

Hass et al Cost-effectiveness of medical and chiropractic care for acute and chronic low back pain J Manipulative Physiol Ther. 2005 Oct;28(8):555-63.

Texas Labor Code 408.021

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest 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 decision before referral to the IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

## **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,

Wendy Perelli, CEO

**I hereby certify, in accordance with TDI/DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the DWC via facsimile, U.S. Postal Service or both on this 13<sup>th</sup> day of February 2006**

**Signature of Specialty IRO Representative:**

**Name of Specialty IRO Representative: Wendy Perelli**