



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.: M5-06-0855-01
South Coast Spine and Rehab, P. A. 620 Paredes Line Road Brownsville, TX 78521	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Brownsville ISD, Box 29	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, "We are requesting a Medical Dispute Resolution pursuant to Rule 133.308. We have completed the appropriate sections of the DWC-60 Form and attached it."

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)
7-6-05 – 9-8-05	CPT code 99213 (\$61.89 X 19 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1175.91
7-6-05 – 9-8-05	CPT code 97124 (\$26.63 X 34 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$905.42
7-6-05 – 9-8-05	CPT code 97113 (\$38.05 X 20 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$761.00
7-6-05 – 9-8-05	CPT code 97032 (\$19.00 X 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$228.00
7-6-05 – 9-8-05	CPT code 97035 (\$14.63 X 11 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$160.93
7-6-05 – 9-8-05	CPT code 90801	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$182.15
7-6-05 – 9-8-05	CPT code 97110 (\$33.56 X 44 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1476.64
7-6-05 – 9-8-05	CPT code 97750-FC- (\$35.63 X 8 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$285.04
Grand Total			\$5,175.09

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$5,175.09.

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 \$5,175.09. 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 by:

Donna Auby

3-21-06

Order by:

Margaret Ojeda

3-21-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0855-01
NAME OF REQUESTOR: South Coast Spine and Rehab, P.A.
NAME OF PROVIDER: E. Ray Strong, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 03/10/06 (REVISED 03/13/06)

Dear South Coast Spine and Rehab, P.A.:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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.

REVIEWER REPORT

Information Provided for Review:

An undated job description from Brownsville Independent School District

An evaluation with Robert S. Howell, D.C. dated 05/25/05

A CT scan of the lumbar spine interpreted by Marc Berger, M.D. dated 05/27/05

Evaluations with E. Ray Strong, D.C. dated 06/06/05, 06/22/05, 07/06/05, 07/07/05, 07/11/05, 07/13/05, 07/21/05, 07/25/05, 07/28/05, 08/01/05, 08/03/05, 08/10/05, 08/11/05, 08/15/05, 08/17/05, 08/18/05, 08/22/05, 08/24/05, 08/29/05, 08/31/05, 09/06/05, 09/07/05, 09/08/05, and 09/12/05

An evaluation with Karen Dickerson, M.D. dated 06/07/05

Functional Capacity Evaluations (FCEs) with Dr. Strong dated 06/22/05 and 08/15/05

An MRI of the lumbar spine interpreted by Dr. Berger dated 06/24/05
An evaluation with Humberto Tijerina, M.D. dated 06/24/05
An evaluation with Rick Moses, Ph.D., L.M.F.T. dated 07/18/05
Evaluations with Tim S. Chowdhury, M.D. dated 07/21/05 and 10/11/05
An evaluation with Jorge E. Tijmes, M.D. dated 09/27/05
A Required Medical Evaluation (RME) with Gregory S. Goldsmith, M.D. dated 10/10/05
An undated chronological order of case management form

Clinical History Summarized:

On 05/25/05, Dr. Howell recommended chiropractic therapy, a CT scan of the lumbar spine, and an FCE. The CT scan of the lumbar spine interpreted by Dr. Berger on 05/27/05 revealed disc protrusions from L2-S1. An FCE performed with Dr. Strong on 06/22/05 indicated the patient could function in the sedentary physical demand level. An MRI of the lumbar spine interpreted by Dr. Berger on 06/24/05 revealed levoscoliosis of the spine, disc bulges at L4-L5 and L5-S1, and an incidental finding of a left ovarian cyst with leakage of fluid. Aquatic therapy was performed with Dr. Strong from 07/07/05 through 08/03/05 for a total of nine sessions. On 07/18/05, Dr. Moses recommended six individual therapy and biofeedback sessions. On 07/21/05, Dr. Chowdhury recommended two lumbar epidural steroid injections (ESIs). On 08/03/05, Dr. Strong recommended continued chiropractic therapy. Chiropractic therapy continued with Dr. Strong from 08/10/05 through 09/12/05 for a total of 13 sessions. Another FCE with Dr. Strong on 08/15/05 was unchanged. Dr. Tijmes recommended continued therapy and medications on 09/27/05. On 10/10/05, Dr. Goldsmith recommended electrical studies and a CT discogram. On 10/11/05, Dr. Chowdhury again recommended lumbar ESIs and continued medications. An undated chronological order of case management form indicated medication prescriptions, two ESIs, and the individual psychotherapy and biofeedback sessions had all been denied.

Disputed Services:

Office visits, massage, aquatic therapy, electrical stimulation, ultrasound, diagnostic interview, therapeutic exercises, and an FCE from 07/06/05 through 09/08/05

Decision:

I agree with the requestor. The office visits, massage, aquatic therapy, electrical stimulation, ultrasound, diagnostic interview, therapeutic exercises, and an FCE from 07/06/05 through 09/08/05 were medically reasonable and necessary.

Rationale/Basis for Decision:

According to the medical records provided for review, the patient injured her low back on _____. She began treatment on 05/25/05 that included office visits, massage, aquatic therapy, electrical stimulation, ultrasound, diagnostic interviews, and therapeutic exercises. The treatment dates in question are from 07/06/05 through 09/08/05. According to the North American Spine Society Phase III Clinical Guidelines for Multidisciplinary Spine Care Specialists, 2003, passive modalities and therapeutic exercises are allowable treatments in the initial and secondary phase of care. The guidelines also state the initial and secondary phases of care can last up to 16 weeks from the date of injury. The medical records show the treatments in question fall within the acceptable guidelines for treatment of the lumbar spine. The dates in question, 07/06/05 through 09/08/05, falls within the 16 week limit provided by the previously stated guidelines. In short, the office visits, massage, aquatic thereapy, electrical stimulation, ultrasound, diagnostic interviews, therapeutic exercises, and an FCE from 07/06/05 through 09/08/05 were medically necessary to treat this patient.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 03/13/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel