



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:  Health Care Provider    Injured Employee    Insurance Carrier

Requestor's Name and Address:

**Julio Fajardo DC**  
**2121 N Main Street**  
**Fort Worth TX 76106**

New MDR Tracking No.: M5-06-0921-01

Old MDR Tracking No.: M5-06-0515-01

Claim No.:

Injured Worker's Name:

Respondent's Name and Address:

**Texas Mutual Insurance      Box 54**

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Medically necessary during active PT and for f/u evaluation.

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

Response to DWC-60 package. Position Summary: Carrier requests that the request for dispute resolution be conducted under the provisions of the APA.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-7-05 to 4-25-05	97035    \$15.11/unit x 4 units = \$60.44	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,700.00
	97140    \$33.04/unit x 15 units = \$495.60		
	99212    \$48.03 x 2 days = \$96.06		
	97110    \$34.93/unit x 30 units = \$1047.90		
	Total		\$1,700.00

#### 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 **prevailed** on the disputed medical necessity issues.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 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 additional reimbursement in the amount of \$1700.00. 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 \$650.00. 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:

Medical Dispute Officer

2-8-06

\_\_\_\_\_  
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.**

# P-IRO

An Independent Review Organization

7626 Parkview Circle

Austin, Texas 78731

**Phone: 512-346-5040**

**Fax: 512-692-2924**

Amended February 7, 2006

January 31, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Delivered via Fax

Patient / Injured Employee \_\_\_\_\_

TDI-DWC # \_\_\_\_\_

New MDR Tracking # \_\_\_\_\_

M5-06-0921-01

MDR Tracking #: \_\_\_\_\_

M5-06-0515-01

IRO #: \_\_\_\_\_

5312

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

P-IRO 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. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO 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, information provided by The Requestor, Respondent, and Treating Doctor(s), including: Insurance Company, including but not limited to IRO request, Notification of IRO Assignment, DTI form MR-117, DTI-60, associated EOB's, Request for reconsideration dated 6-14-2005, 8-29-2005, Follow-up medical report Dr. Ved Aggarwai, MD dated 3-21-2005, 3-31-2005, 4-11-2005, 4-21-2005, 4-26-2005, Texas Injury Clinic Daily SOAP notes dated 2-18-2005, 2-28-2005, 3-16-2005, 3-14-2005, 4-4-05, 4-6-05, 4-08-05, 4-11-05, 4-13-05, 4-18-05, 4-25-05, MRI lumbar spine dated 2-07-2005, Texas Injury Clinic Physical Performance Eval dated 3-1-2005, 4-28-2005, Texas Mutual MDR response dated 1-24-2006, TWCC assignment of new tracking number dated 1-19-2006, Texas Injury Clinic report dated 1-12-2005, re-eval dated 3-14-2005, Daily notes 1-13-2005, 2-07-2005, 2-28-2005, 3-18-2005,

3-21-2005,4-11-2005, 4-25-2005, TWCC PLN111 Notice of Disputed issues regarding left wrist/forearm/middle & index finger dated 1-24-2005, Dr. Ved Aggarwal MD initial report dated 2-21-2005, follow-up report 4-11-2005, 4-26-2005, 6-6-2005, 7-12-2005, EMG/NCV report Gary Gottfried MD dated 3-2-2005, Texas Designated Doctor Examination dated 4-01-2005, 8-01-2005, FCE dated 4-28-2005, 6-28-2005, Spinal Solutions Neurosurgical Examination dated 8-1-2005, Optima Medical Group RME dated 11-08-2005

### **CLINICAL HISTORY**

The Patient apparently sustained a work related injury on \_\_\_\_, while working for \_\_\_\_ . The Patient apparently was performing repetitive forceful movements with a sledge hammer, when he injured his low back. The Patient sought treatment with Texas Injury Clinic on 1-12-2005, where The Patient was evaluated and therapy was recommended. The Patient was eventually referred for an MRI of the lumbar spine, which revealed an annular bulge at L2-3 and L3-4 and 1-2mm annular bulge at L4-5. The Patient was referred to Ved Aggarwal MD, who recommended LESI. The Patient was seen by a TWCC Designated Doctor on 4-01-2005 and again on 8-01-2005 at both times he had not reached MMI. The Patient apparently underwent a LESI on 3-09-2005. The Patient was prescribed various pharmaceuticals throughout the treatment protocol. The Patient underwent a neurotomy on the right at L3-4, L4-5, and L5-S1 on 5-18-2005. On 6-06-005 the left side was recommended by Dr. Aggarwal. The Patient underwent facet injection on 4-21-2005 and 07-06-2005.

### **DISPUTED SERVICE (S)**

Under dispute is the retrospective medical necessity of 97035-ULTRASOUND, 97140-MANUAL THERAPY, 99212-OV, 97110-THERAPEUTIC EXERCISES.

### **DETERMINATION / DECISION**

The Reviewer disagrees with the determination of the insurance carrier.

### **RATIONALE/BASIS FOR THE DECISION**

Based on the clinical evidence and documentation, The Reviewers assessment is that the disputed services were medically necessary. The Patient injured his low back using heavy equipment. MRI of the lumbar spine is positive for disc pathology. EMG/NCV findings are positive and consistent with an acute injury neurological injury. The Patient underwent several different types of injections, which post-injection therapy is medically necessary. The Patient was seen by Designated Doctor on two separate occasions and determined that The Patient was not at MMI. Medical necessity is additionally supported by other physicians from different specialties. Additionally, other providers/records supported the medical necessity throughout care.

### **Screening Criteria**

#### **1. 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**

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

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

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,  
**P-IRO Inc.**



Ashton Prejean

**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 DWC via facsimile, U.S. Postal Service or both on this 31<sup>st</sup> day of January 2006.

Name and Signature of P-IRO Representative:

Sincerely,  
**P-IRO Inc.**

A handwritten signature in black ink that reads "Ashton Prejean". The signature is written in a cursive style with a large initial 'A'.

Ashton Prejean  
**President & Chief Resolutions Officer**