



**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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address:  Valley Spine Medical Center 5327 South McColl Rd. Edinburg, Texas 78539	MDR Tracking No.: M5-06-0997-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  TX Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Documents include the DWC-60 package. Position Summary (Table of Disputed Services) states, "The care rendered has met criteria set by Texas Labor Code section 408.21."

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

Documents include the DWC-60 response. Position Summary states, "Request that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

#### 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)
2-3-05 – 5-31-05	CPT codes 97124, 97035, 97140, 97110, 99212, G0283, 97750	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

#### 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 additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Donna Auby

4-10-06

Authorized Signature

Typed Name

Date of Findings and Decision

**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 Medical Dispute Resolution M5 Retrospective Medical Necessity  
IRO Decision Notification Letter**

<b>Date:</b>	<b>04/03/2006</b>
<b>Injured Employee:</b>	
<b>MDR #:</b>	<b>M5-06-0997-01</b>
<b>DWC #:</b>	
<b>MCMC Certification #:</b>	<b>TDI IRO-5294</b>

**REQUESTED SERVICES:**

Please review the item(s) in dispute: Massage therapy (97124), ultrasound (97035), manual therapy technique (97140), therapeutic exercises (97110), office visits (99212), electrical stimulation (G0283) and physical performance test or measurement with written report (97750).

Dates of service (DOS): 02/03/2005-05/31/2005

**DECISION: Upheld**

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IRO MCMCllc (MCMC) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO) to render a recommendation regarding the medical necessity of the above disputed service.

**Please be advised that a MCMC Physician Advisor has determined that your request for an M5 Retrospective Medical Dispute Resolution on 04/03/2006, concerning the medical necessity of the above referenced requested service, hereby finds the following:**

The medical necessity for the list of services listed above from 02/03/2005 through 05/31/2005 is not established.

**CLINICAL HISTORY:**

Records indicate that the above captioned individual, a 54-year-old female, was injured during the course of her normal employment on or about \_\_\_\_\_. MRI examination of the right knee dated 11/11/2004 revealed a medial meniscal tear. Surgery was performed to the right knee on 01/18/2005. The procedure is described as arthroscopy and partial medial meniscectomy. A course of rehabilitation was initiated following surgery. An MRI dated 11/14/2005 revealed post-operative changes as well as a sprain of the anterior cruciate ligament with no additional ligamentous or meniscal tearing.

**REFERENCES:**

- ACEOM Guidelines
- Health Care Guidelines by Milliman and Robertson Volume 7, North American Spine Society Guidelines
- Texas Medical Fee Guidelines and Procedural Utilization Guidelines.

**RATIONALE:**

The documentation fails to establish the medical necessity for the list of services captioned above. The submitted records indicate that the injured individual underwent surgery on 01/18/2005. It is unclear what treatment had transpired before that time, however given the surgery dated 01/18/2005, it is possible that the injured individual was a candidate for postoperative therapy. However in this particular case, there are no associated examination findings or treatment goals prior to the initiation of post surgical therapy. It

appears that a physical performance test was administered at the conclusion of the course of post surgical rehabilitation, however there are no prior examination findings with which to compare and to demonstrate that the course of care following surgery was even therapeutically beneficial. The course of post surgical rehabilitation should have been preceded by an examination with the compilation of objective data to provide a baseline of data and/or to show that the injured individual was performing below the job required physical demand level. This initial exam would also provide treatment goals and expectations for recovery and a return to

work. The earliest associated daily note is dated 02/03/2005. There are no exam findings and the notes are sparse at best. The information contained in the daily notes do not justify or substantiate the need for an extensive course of post surgical rehabilitation to include as many as five units of active rehabilitation with additional passive modalities. The submitted notes simply do not establish that there were significant objective findings as of 02/03/2005.

**RECORDS REVIEWED:**

- Notification of IRO Assignment dated 03/01/06
- MR-117 dated 03/01/06
- DWC-60
- MCMC: IRO Medical Dispute Resolution Retrospective Medical Necessity dated 03/13/06
- MCMC: IRO Acknowledgment and Invoice Notification Letter dated 03/01/06
- Texas Mutual: Letter dated 02/15/06
- Open MRI of McAllen: MRI right knee dated 11/14/05, 11/11/04
- Valley Spine Medical Center: Requests for Reconsideration dated 07/12/05, 05/17/05, 05/05/05 from Janie Chavez
- Texas Mutual: Explanation of Benefits with Dates of Audit 03/01/05, 03/15/05, 03/21/05, 04/22/05, 05/04/05, 05/06/05, 05/26/05, 05/27/05, 06/10/05, 06/23/05, 08/04/05
- Valley Spine Medical Center: Chart note dated 02/18/05 from Pete Garcia, M.D.
- Health Insurance Claim Forms dated 02/11/05 through 07/11/05
- Therapeutic Procedure Charts dated 02/09/05 through 03/17/05
- Valley Spine Medical Center: Progress Notes (handwritten) dated 02/03/05 through 03/1/05
- Cornerstone Regional Hospital: Operative Report dated 01/18/05 from Pedro Garcia, Jr., M.D.

**The reviewing provider is a Licensed/Boarded Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor 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 prior to referral to the IRO. The reviewing physician is on DWC's Approved Doctor List.**

**This decision by MCMC is deemed to be a Division decision and order (133.308(p) (5).**

**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.

**In accordance with Division rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of DWC on this**

**30<sup>th</sup> day of April 2006.**

**Signature of IRO Employee:** \_\_\_\_\_

**Printed Name of IRO Employee:** \_\_\_\_\_