



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: <b>Patrick R E Davis DC 115 W Wheatland Rd Suite 101 Duncanville TX 75116</b>	MDR Tracking No.: M5-06-1062-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: <b>Liberty Mutual Box 28</b>	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DWC-60 package. Position summary: Documentation supports medical necessity.

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

Response to DWC-60 package. Position summary: Not medically necessary per peer review.

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due (if any)
3-25-05 to 4-22-05	99215, 97035-59, 97112-59, 97140-59, 97530-59	<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

5-16-06

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**

April 3, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TDI-DWC #:

MDR Tracking #:

IRO #:

M5-06-1062-01

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: Explanation of payment, notes from treating doctor, upper extremity NCV/EMG, Cervical MRI, peer review from Thomas Sato DC.

## CLINICAL HISTORY

At the time of the injury this was a 63-year-old male who was injured on \_\_\_\_\_, performing job duties as a maintenance and mechanical laborer for \_\_\_\_\_. On that morning, the patient was turning on screw compressors and regulating air pressure by manipulating/ maneuvering designated valves. As the patient turned on one of the valves, which failed to have a "Locked and Tagged" status, a component of the valve under significant pressure impacted his left upper head and knocked him backwards. The patient stated that his head and neck was jarred/ jolted back. His left upper frontal region began to bleed profusely and was immediately transported to the emergency room.

## DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of office visits-99215, ultrasound-97035-59, neuromuscular re-education-97112-59, manual therapy technique-97140-59, and therapeutic activities-97530-59 for dates of service 3/15/05 through 4/22/05.

## DETERMINATION/DECISION

The Reviewer agrees with the determination of the insurance company.

## RATIONALE/BASIS FOR THE DECISION

The Reviewer agrees with Dr. Sato's peer review, in that there is no history or examination to document the reason for the exacerbation or the history of The :Patient's activities for the three years prior to the exacerbation. As he referred to in his review, this is a contradiction in care as outlined in the *Official Disability Guidelines* and the *Guidelines For Chiropractic Quality Assurance and Practice Parameters*. The re-exam code of 99215 is the highest-level code and does not meet the requirements for use in this case. The injury is three years prior and there are no documentations of any comorbidity. The use of ultrasound is used in an acute phase of care within two to three weeks post-injury. This passive modality was used three years post injury contradicting the same guideline. The neuromuscular re-education, manual therapy technique, and the therapeutic activities are of no use at this point three years post-injury. First, there must be an expected reasonable positive outcome, which there is none for an exacerbation of pain (these are not pain controlling services), secondly, there are no outcome assessments used to objectively determine any progress, and third, at this point the patient should have been made responsible to carry on a home exercise program to prevent regression from his initial treatments and to continue with the level of conditioning at the time of his release from care. The use of the -59 modifier is misused with the 97035, 97112, and 97530 codes. This modifier is used to unbundle the services since it indicates that two codes may overlap in service, such as the 98940 and the 97140 codes. There are no reasons to unbundle the 97035, 97112, or the 97530 codes. There is no need for the 97140 code since it overlaps the 98940 Chiropractic manipulative therapy code. An exacerbation this far post-injury could have been treated with a trial of two to three weeks of chiropractic manipulations and re-enforcement of a home exercise program with at home cryotherapy on an as needed basis. Therefore, the services in dispute are not reasonable or medically necessary.

## Screening Criteria

### 1. Specific:

- Official Disability Guidelines
- Guidelines For Chiropractic Quality Assurance and Practice Parameters

### 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 3<sup>rd</sup> day of April, 2006.

Name and Signature of IRO America Representative:

Sincerely,

**IRO America Inc.**



Dr. Roger Glenn Brown

**President & Chief Resolutions Officer**