



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

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestors Name and Address: First Rio Valley Medical, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M5-06-1364-01 (current MDR#) M4-04-8306-01 (former MDR#) Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Rep Box # 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "This dispute is a medical fee dispute and not a medical necessity dispute. Medical necessity is not an issue in a medical fee dispute. According to Rule 133.307(a)."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "...In particular please note, the dispute has been marked as "fee reimbursement" only but the dispute is also a "retrospective medical necessity" dispute. The medical necessity issues must be resolved prior to the handling of the medical fee issue."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-20-03	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
05-20-03	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$71.00
05-21-03, 05-22-03 and 05-29-03	97113 (1 unit @ \$52.00 X 4 units = \$208.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$624.00

05-21-03, 05-22-03 and 05-29-03	97032 (1 unit @ \$22.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$66.00
05-21-03, 05-22-03 and 05-29-03	97124 (1 unit @ \$28.00 X 2 units = \$56.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$168.00
05-21-03 and 05-22- 03	99211 (\$18.00 X 3 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$54.00
05-29-03	97139-SS	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$35.00
TOTAL DUE			\$1,033.00

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 prevail** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 reimbursement in the amount of \$1,033.00. 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 \$460.00. The Division hereby **ORDERS** the Respondent 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.

Order by:

Medical Dispute
Officer

09-27-06

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

August 15, 2006

Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MRD#: M5-06-1364-01
DWC#: _____
Injured Employee: _____
DOI: _____
IRO Certificate No.: IRO5317

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional 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.

Information and medical records pertinent to this medical dispute were obtained from First Rio Valley Medical. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractics, and is currently on the DWC Approved Doctor list.

Sincerely,

John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by First Rio Valley Medical:

Office visits (02/26/01 – 05/22/03)

Peer Review (10/15/2002)

Therapy Notes (05/21/2003 – 05/29/2003)

Clinical History:

This is a 56-year-old female food service worker, who slipped and fell on the melted ice on the floor sustaining injury to her neck and back. Robert Howell, D.C., evaluated the patient for low back pain radiating to the legs and neck pain with radiation into the shoulders. The spine was tender to palpation. He diagnosed cervical, thoracic, and lumbosacral sprain. Therapy of six weeks was planned for the patient.

Information gathered from a case management report: Electrodiagnostic study revealed mononeuropathy of the right peroneal nerve and left tibial nerves; proximal motor neuropathy of the bilateral peroneal nerves at L4; and proximal sensory neuropathy at left sural nerve. Magnetic resonance imaging (MRI) of the thoracic spine revealed straightening of the spine. MRI of the lumbar spine revealed hypolordosis. Electrodiagnostic study of the upper extremities revealed impairment at C6, C7, and C8 nerve roots. MRI of the cervical spine revealed reversal of the upper cervical curve. Shahid Rashid, M.D., a pain specialist, had recommended right L4, L5, and S1 epidural steroid injections (ESI). Aquatic therapy was recommended.

In 2002, in a peer review, John Braswell, D.C., rendered the following opinions: (1) The initial treatment was excessive. She should have been returned to work with restrictions. (2) No further diagnostic studies or aggressive care was required. (3) MRIs and durable medical equipment (DMEs) including analgesic ointments, ice packs, and orthotics were not medically necessary. (4) The injury had resolved within eight weeks following the injury. She was at maximum medical improvement (MMI) as of April 21, 2001.

On May 20, 2003, Dr. Howell saw the patient for exacerbation of the low back pain. The patient had tried over-the-counter (OTC) medications and exercises, but the pain did not subside. Dr. Howell planned physical therapy (PT), three times per week for two weeks. He referred her to Dr. Rashid for pain management. The patient was released to regular duty, per DWC-73. An orthopedic lumbar cushion and Biofreeze was prescribed. From May 21, 2003, through May 29, 2003, the patient attended three sessions of PT consisting of massage, aquatic therapy, interferential current, and electrical muscle stimulation (EMS). Dr. Rashid evaluated the patient and diagnosed right lumbar radiculopathy, lumbar intervertebral disc displacement, lumbar facet dysfunction, myofascial pain syndrome, and discogenic pain. He prescribed Vioxx and Ultracet and planned a lumbar ESI. No medical records available for review from 2004 through 2006.

Disputed Services:

97124 (massage), 97113 (aquatic therapy), 99080-73 (DWC-73 report), 99214 (office visit), 97032 (electrical stimulation), and 97139-SS (unlisted therapy).

Dates of Service (5/20/03 – 5/29/03).

Explanation of Findings:

After reviewing the medical records provided, it was found that the claimant was injured on _____. The patient was initially evaluated by her treating doctor on 2-26-01. Her eventual diagnoses were cervical, thoracic, and lumbar sprain/strains. The claimant was seen in her treating doctor's office on 5-20-03 for what the records state was a re-exacerbation (temporary worsening of a pre-existing condition) of her previous injury. According to the North American Spine Society's Clinical Guidelines for multidisciplinary spine care specialists, 2003, one of the clinical indicators for phase one treatment is an acute recurrence or exacerbation. According to these same guidelines, passive modalities and exercises are interventions that are acceptable in phase one of treatment. Thus, the aquatic therapy, massage, EMS, TWCC-73 report, and unlisted therapy were medically necessary to treat this claimant.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

Overturn Denial

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

North American Spine Society's clinical guidelines for multidisciplinary spine care specialists.

The physician providing this review is a chiropractor. The reviewer is national board certified in chiropractic. The reviewer has been in active practice for seven years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional

associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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.