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 and Fee Dispute

PART I: GENERAL INFORMATION

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

Requestor=s Name and Address:	MDR Tracking No.: M5-06-1420-01
Valley Spine Medical Center **5327 South McColl Rd** **Edinburg TX 78539**	Claim No.:
	Injured Worker's Name:
Respondent's Name:	Date of Injury:
Texas Mutual Insurance Rep Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary taken from the Table of Disputed Services states, "The care rendered to the patient has met criteria set by Texas Labor code section [sic] 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute."

Principle Documentation:
1. DWC-60 package
2. CMS 1500s
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "…Texas Mutual requests that the request for dispute resolution filed by **VALLEY SPINE MEDICAL CENTER,** be conducted under the provisions of the APA…".

Principle Documentation: 1. Response to DWC-60 package

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Amount Due
5-16-05 to 7-5-05	97035 x 1 unit x 20 days	☒ Yes ☐ No	$ 292.60
	99212, 99212-25 x 12 DOS	☒ Yes ☐ No	$ 543.12
	97110 x 1 unit x 32 DOS	☒ Yes ☐ No	$1,074.00
6-6-05	99080-73	☒ Yes ☐ No	$ 15.00
5-16-05 to 7-5-05	99214, 97140	☐ Yes ☒ No	$ 0.00
			$1,909.72

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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.031
28 Texas Administrative Code Sec. 134.1, 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 reimbursement of $1,909.72. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO of $460.00. 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 Resolution Officer	8-28-06
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

June 20, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:
TDI-DWC #:
MDR Tracking #: M5-06-1420-01
IRO #: 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 Case Assignment, Medical Records from Requestor, Respondent, and Treating Doctor (s), including: explanation of benefits, progress notes from Valley Spine Medical Center, operative report from Armando Moncada MD, notes from Alex Flores DC, and notes from Gerardo Zavala MD.

CLINICAL HISTORY

This Patient works as a migrant field laborer. He his responsible for cutting and picking up fruits, vegetables, grains, etc. He states he has to put the produce into boxes and load the heavy boxes. He stated that on the day of the injury, ___ , he was cutting the stalks of celery in the fields when he accidentally swung the machete with his right hand and hit his left hand that was grabbing the bottom of a celery plant. He stated he initially didn't feel pain but just a warm sensation to his left hand. He looked down and saw his left index finger completely cut off and his left thumb dangling by the skin.

DISPUTED SERVICE

Under dispute is the prospective and/or concurrent, retrospective medical necessity of 97035-ultrasound, 97140-manual therapy technique, 99212/99214-office visit, 97110-therapuetic exercise, 99080-73-report for dates of service 5/16/2005 through 7/05/2005.

DETERMINATION / DECISION

The Reviewer partially agrees with the determination of the insurance carrier in this case. The Reviewer agrees with the insurance carrier on the following: office visit-99214, manual therapy technique-97140; the Reviewer disagrees with insurance carrier on the following: ultrasound-97035, office visit-99212, therapeutic exercise-97110, and reports-99080-73.

RATIONALE / BASIS FOR DECISION

Based on the records provided and the history of the injury, the treatment of ultrasound and therapeutic exercise is reasonable and necessary according to the *Official Disability Guidelines,* the *ACOEM* and the *Texas Guidelines for Quality Assurance and Practice Parameters*. Office visits are required to assess The Patient's progress/regression and to determine if the treatment plan is achieving the desired goals. TWC reports are used to update The Patient's progress to the involved parties. Manual therapy is not reasonable for this type of injury since therapeutic exercises are utilized. The office visit code of 99214 is coded too high for this case. A high degree of morbidity or mortality would suggest the use of the 99214 or 99215 re-evaluation codes; however, this is not reasonable or necessary in this case.

Screening Criteria

1. Specific:

- Texas Guideline for Chiropractic Quality Assurance and Practice Parameters
- ACOEM
- Official Disability Guidelines

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 20 day of June, 2006.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Name and Signature of IRO America Representative: