



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: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-1574-01
Rogelio Rodriguez, D. C. 4602 Washington Ave. Suite A Houston, TX 77007	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Liberty Insurance Corp., Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Treatment medically necessary for extent of injury (as per medical documentation, post-injection and diagnostics.)"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Not medically necessary per peer review."

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)
5-4-05, 6-1-05, 7-6-05, 8-1-05	CPT code 99213 (\$67.20 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$268.80
5-4-05 – 8-5-05	CPT codes 99213 (dates of service not listed above), 99212, 99214, 99215, 97110, 97140	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
	Total		\$268.80

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$268.80.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

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 requestor is not due a refund of the IRO fee. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$268.80. 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.

Findings and Decision and Order by:

Authorized Signature

Typed Name

6-20-06

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.

NOTICE OF INDEPENDENT REVIEW DECISION

June 5, 2006

Program Administrator
Medical Review Division
Division of Workers Compensation
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Claim #:
Injured Worker:
MDR Tracking #: M5-06-1574-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in specialty. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and 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 IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained a work related injury on ___ when he was lifting sheetrock from the ground and loading it onto a dolly. He felt pain at the neck, upper back and low back areas. An MRI of the lumbar spine revealed annular disc bulge with posterior herniation at level L3-4 and L4-5. An MRI of the cervical spine revealed herniations at C3 through C7.

Requested Service(s)

Office visits (99212), (99213), (99214), (99215), therapeutic exercises (97710), and manual therapy technique (97140) provided from 05/04/2005 to 08/05/2005.

Decision

It is determined that one office visit (99213) on a monthly bases from 05/04/2005 to 08/05/2005 was medically necessary to treat this patient's condition.

It is determined that the office visits (99212), (99214), (99215), therapeutic exercises (97710), and manual therapy technique (97140) provided from 05/04/2005 to 08/05/2005 were not medically necessary.

Rationale/Basis for Decision

National treatment guidelines allow for treatment of these types of injuries. They do not allow for the intense treatment this patient received as a result of his injury. The records indicate he initially received physical therapy in February, March, and April 2005 and that was appropriate treatment. He then began epidural steroid injections (ESI's) in May of 2005. There is discussion in the records that indicate utilization of in office therapy in conjunction with ESI's have been shown to be necessary. However, in this case there is no documentation to clinically justify this need. The patient had already participated in an aggressive therapy program and should have been instructed in an appropriate home exercise program to be utilized in conjunction with ESI's.

The Functional capacity evaluation (FCE) dated 04/21/2005 reveals the patient was functioning at a sedentary level and that was after months of physical therapy. The FCE dated 07/12/2005 determined he was functioning at a light level and again this was after an additional three months of therapeutic exercises. The minimal response to treatment confirms the lack of medical necessity for the therapy during the stated time frame.

Therefore, the office visits (99212), (99214), and (99215), therapeutic exercises and manual therapy technique from 05/04/2005 through 08/05/2005 were not medically necessary to treat this patient's condition. An office visit (99213) on a monthly basis in order to case manage this patient's condition would be appropriate.

This decision by the IRO is deemed to be a DWC decision and order.

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 that 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.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

Information Submitted to TMF for Review

Patient Name: _____ Tracking #: M5-06-1574-01

Information Submitted by Requestor:

- Appeal letter Chiropractic and Wellness Care
- Initial Medical Report
- MRI report of lumbar spine
- MRI report of cervical spine
- Initial Patient Consult
- Nerve Conduction Studies
- Subsequent Medical Reports
- Request for Physical Therapy
- Letters from Dr. Rodriguez
- MRI report of thoracic spine
- Follow up notes
- Independent medical examination
- Functional Capacity Evaluations
- Operative Reports
- RME Disagreement
- History and Physical by Dr. Perkins
- Decision Letters
- Daily Patient Records

Information Submitted by Respondent:

- Reconsideration
- Billing Retrospective Review
- Notes from Concentra Medical Centers
- Daily Patient Records
- Initial Medical Report
- MRI report of lumbar spine
- MRI report of cervical spine
- Initial Patient Consultation
- Special Report For "Unlisted Procedure"
- Nerve Conduction Studies
- Letters from Dr. Rodriguez
- MRI report of thoracic spine
- Functional Capacity Evaluations
- Surveillance Report
- Subsequent Medical Reports
- Independent Medical Examination
- Anesthesia Record
- Follow up Notes
- Operative Reports
- Anesthesia Record
- Maximum Medical Improvement/Impairment Rating
- Assessment/Physical Examination
- Work Hardening Schedule
- Group Focus