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

Requestors Name and Address: Physiotherapy of El Paso dba Spine & Rehab 2900 Pershing Drive, Suite B El Paso, Texas 79903	MDR Tracking No.: M5-06-1650-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Rep box # 28	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: None submitted to MDR by Requestor

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: None submitted to MDR by the Respondent

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS (Medical Necessity)

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07-21-05 to 09-30-05	G0283, 97110, 97035, 97113, 97140 and 97002-59	☐ Yes ☒ 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.

P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)

The Requestor submitted an updated Table of Disputed Services on 05-31-06 which was used for this review.

On 07-31-06 the Requestor submitted information to Medical Dispute Resolution regarding dates of service 07-11-05, 07-13-05 and 07-18-05 which had been paid and therefore were no longer in dispute.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

PART VII: DIVISION FINDINGS AND 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:

		08-08-06
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.

INDEPENDENT REVIEW INCORPORATED

July 11, 2006

Re:	**MDR #:**	**M5 06 1650 01**	**Injured Employee:**	___
	DWC #:	___	**DOI:**	___
	IRO Cert. #:	**5055**	**SS#:**	___

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention: ___
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **Liberty Mutual**

REQUESTOR: **Physiotherapy of El Paso**

TREATING DOCTOR: **Helson Pacheco-Serrant, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. 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, 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.

Sincerely,

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M5 06 1650 01

Information Provided for Review:

Extensive medical records provided by the requestor and the carrier have been reviewed. They include DWC's assignment, medical dispute resolution requests, table of disputed services, multiple explanation of benefits, multiple peer reviews, and physical therapy reviews, designated doctor report from Dr. Filbrick with addendum and correspondence, impairment rating from Dr. Filbrick, notes from El Paso Orthopedic Surgery Group, Dr. Helson Pacheco-Serrant, physical therapy from Spine and Rehab Specialists, MRI report of the lumbar spine from Open MRI in El Paso, 2 operative reports from Dr. Pacheco-Serrant first dated 09/16/04 and the second dated 01/04/05, field investigator work, and Workers' Compensation Compensability Investigation Report dated 01/26/05.

Clinical History:

The patient is a 31-year-old female who worked for .
She injured her low back while at work on ___. She slipped on some ice at work and injured her lower back and right leg. She was diagnosed with a low back sprain, and MRI scan revealed a disc herniation at L5/S1 and a smaller one at L4/L5. She eventually underwent a 360-degree fusion and decompression from L4 to S1 by Dr. Pacheco on 09/16/04 with no complications. On 01/04/05 a complication was found with displacement of the L4/L5 interbody implant, which was revised on that day. She received physical therapy prior to her surgery and also received physical therapy after her initial surgery. It was started on 10/28/04. This was found when the implant was found to be displaced. After the revision of L4/L5 fusion, therapy was started approximately 2-1/2 weeks after the second revision operation.

Disputed Services:

Electrical stimulation, therapeutic exercises, ultrasound, aquatic therapy, manual therapy techniques, and physical therapy re-evaluations from 07/21/05 through 09/30/05.

Decision:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

Rationale:

Although this patient had a very complicated initial surgery and complication, the complication was treated on 01/04/05 without further complications. The patient had atrophy prior to her initial surgery, and the operating surgeon's rational for continued therapy of almost 7 or 8 months' duration was necessity because of the atrophy. If significant neural injury had occurred, it is possible that this atrophy will never resolve, and atrophy is not an indication for ongoing therapy as neural regeneration would need to occur prior to any effects of physical therapy to strengthen that muscle. In addition, the therapy documentation reports that the patient's pain level was under control, and she was quite functional during the disputed dates. In addition, it was demonstrated in the physical therapy records that she was well aware and able to perform a home exercise program at that time.

Guidelines/Publications Referenced:

The medical documentation provided as well as physical therapy guidelines and disability guidelines for this patient's diagnosis.