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.: M5-06-2137-01
Gabriel Gutierrez, D. C. P.O. Box 229 Katy, TX 77492-0229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
LIBERTY MUTUAL INSURANCE CO, Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "…Full payment for reasonable and necessary medical treatment and/or services appealed is expected as well as interest due for late payment of medical bills as per Rule 133.304…and Rule 134.803..."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "Not medically necessary per peer review."

Principle Documentation:

1. DWC-60/Table of Disputed Service

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)
9-30-05	99212	☒ Yes ☐ No	$37.04<MAR
9-30-05 – 11-09-05	97110 (62 units x $35.86)	☒ Yes ☐ No	$2,223.32
	Total Due		$2,260.36

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. Per Rule 134.202(c)(1) and (d)(2) the amount due the Requestor for the items denied for medical necessity is $2,260.36.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 carrier must refund the amount of the IRO fee ($460.00) to the Requestor within 30 days of receipt of this order. The Division has determined that the Requestor is entitled to additional reimbursement in the amount of $2,260.36. 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.

Findings and Decision and Order by:

	Medical Dispute Officer	01-08-07
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.

INDEPENDENT REVIEW INCORPORATED

December 4, 2006

Re: **MDR #: M5 06 2137 01** **Injured Employee:** ____
DWC #: **DOI:**
IRO Cert. #: 5055

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation

Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **Liberty Mutual**

TREATING DOCTOR: **Gabriel Gutierrez, DC**

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 chiropractor who is certified in pain management and is currently listed on the DWC Approved Doctor List.

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
Operations Manager

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

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M5 06 2137 01

MEDICAL INFORMATION REVIEWED:

1. DWC Assignment
2. Records of Gabriel Gutierrez, DC
3. Records of Interactive Pain Management/Houston

BRIEF CLINICAL HISTORY:

The patient fell out of the back of a trailer which is used to haul cargo and injured his left knee, head, neck, left elbow, left shoulder and lower back. Records indicate that his fall was the result of a slip of his leg and when he fell, he landed on his head. His left knee did not respond to conservative treatment and the patient underwent 3 separate surgeries to the knee along with treatment for post-surgical infection. The left elbow pain resolved itself, but the head, neck and low back pain were left untreated by the patient's original treating provider. The patient's care was reviewed by the carrier's provider, Dr. Sato, who recommended 24 post-surgical visits. MRI of the lumbar spine had few findings of interest, but the cervical spine MRI was significant for a C6/C7 right paracentral herniation. The carrier's RME doctor, Dr. Williamson, recommended conservative rehabilitation and physical therapy.

DISPUTED SERVICES:

The carrier has denied the medical necessity of office visits (99212) and therapeutic exercises (97110)

DECISION:

I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

RATIONALE OR BASIS FOR DECISION:

Clearly, this patient's care was reasonable due to not only the left knee being surgically repaired 3 times and then infected, but also the cervical herniation and the lumbar injury that were never addressed by the previous treating doctor. I believe that the care rendered by the subsequent treating doctor was not only reasonable, it was absolutely necessary to return this patient to his work environment. While Dr. Sato's assessment for the case was correct at the time of the review, these cases are almost always dynamic when multiple injuries occur. It is not unusual for a provider to miss injured regions of the body when one area is severe, such as the knee. On occasion, even the patient doesn't realize how severe the injury might be in those areas. Regardless of these possibilities, the actual question is whether the care is reasonable. It would be very near impossible to find approximately 6 weeks of care unnecessary in this case due to the complications which were encountered. The treating doctor did an appropriate job of completing the care of this patient and the care fits within the labor code and any applicable guidelines for the injuries suffered.

SCREENING CRITERIA/TREATMENT GUIDELINES

TCA, Mercy Center guidelines