



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

<b>Type of Requestor:</b> ( X ) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestors Name and Address: Neuromuscular Institute of Texas – P. A. 9502 Computer Drive, Suite 100 San Antonio, TX 78213	MDR Tracking No.: M5-06-2160-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Liberty Mutual Fire Insurance 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: As listed on the Requestor's Table of Disputed Services, "All services provided were based on the patients need and the doctor's professional judgment to relieve the effects of the injury, and were deemed medically necessary."

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: As listed on the Respondent's Table of Disputed Services, patient services were "Unnecessary per peer review."

Principle Documentation:

- 1 Response to DWC-60
- 2 Explanation of Benefits

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
07/11/05	99213 (\$61.89 x 1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$61.89
06/29/05 – 08/15/05	97110-GP (\$33.56 x 18 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$604.13
06/29/05 – 08/15/05	G0283-GP (\$13.61 x 12 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$163.35
06/10/05 – 08/15/05	99212 (\$45.26 x14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$795.05
08/12/05	99214	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 97.40
08/12/06	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
<b>TOTAL</b>			<b>\$1,733.82</b>

**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.

The Requestor has submitted an updated Table of Disputed Services, on 07/24/06, which is the Table used for this Review.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, 134.1, 129.5 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 \$1,733.82. 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

11/29/06

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Date of Findings and Decision or 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.**

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71  
Phone: 512-288-3300

Austin, Texas 78735  
FAX: 512-288-3356

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

**REVISED 11/20/06**

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-2160-01
Name of Patient:	
Name of URA/Payer:	Neuromuscular Institute of Texas
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Brad Burdin, DC

November 2, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Division of Workers' Compensation

**REVISED 11/20/06**

### DOCUMENTS REVIEWED

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Statement of Requestor's position, dated 10/17/06
3. Treating doctor office notes and narratives, multiple dates
4. MRI lumbar spine, dated 7/6/04
5. Two radiographic views of the chest, dated 7/9/04
6. Operative report (left L4-5 laminotomy, mesial facetectomy, and foraminotomy; left L3-4 laminotomy, mesial facetectomy and foraminotomy; and, extirpation of left L4-5 and left L3-4 subligamentous disk hernations), dated 7/9/04
7. Copy of recorded interview of claimant, dated 7/14/04
8. MRI lumbar spine, with and without contrast, dated 8/11/04

9. Operative report (left L4-5 mesial facetectomy, foraminotomy, and discectomy), dated 8/16/04
10. Motor and sensory nerve conduction study, dated 9/29/04
11. Initial evaluation and report, dated 10/15/04
12. Radiographic study, lumbar spine, dated 10/16/04
13. MRI lumbar spine, with and without contrast, dated 10/22/04
14. Lower extremity EMG/NCV and report, dated 11/1/04
15. Lumbar myelogram, and post-myelogram CT, dated 11/15/04
16. Treating doctor "Daily Treatment Logs," multiple dates
17. Referral medical doctor (physician assistant) office notes and narratives, multiple dates
18. Psychotherapy evaluation, dated 12/8/04
19. Occupational therapy notes/exercise logs, multiple dates
20. Patient "Symptom Log," post-injection and post-medication, from 1/7/05 through 1/30/05
21. Pain management referral doctor's office notes, multiple dates
22. Operative report (transforaminal selective nerve blocks), dated 1/7/05
23. Operative report (left-sided L4 and L5 transforaminal selective epidural blocks), dated 2/18/05
24. Required medical examination, dated 3/23/05
25. Operative report (implantation of spinal cord stimulator), dated 3/23/05
26. MRI lumbar spine, with and without contrast, dated 4/1/05
27. Functional Capacity Evaluation, dated 8/17/05
28. Operative report (bilateral S1 lumbar transforaminal epidural steroid injection; bilateral sacroiliac joint injection), dated 8/26/05
29. Treating doctor's impairment rating, dated 8/31/05 and 9/1/05
30. Designated doctor impairment rating, dated 11/29/05
31. Operative report (right and left S1 lumbar transforaminal epidural steroid injections), dated 12/10/05
32. Lower extremity evoked potential study, dated 1/28/06
33. Operative report (transforaminal epidural steroid injection), dated 2/2/06
34. Operative report (transforaminal epidural steroid injection and bilateral sacroiliac joint intra-articular steroid injection), dated 2/17/06
35. Letter of clarification from designated doctor's impairment rating, dated 3/16/06
36. Neurological consultation, dated 1/19/06
37. Orthopedic consultation, dated 2/27/06
38. CT lumbar, with and without contrast, and report, dated 3/8/06
39. CT right ankle, dated 4/3/06
40. Urologist's medical report (for purposes of determining whole-person impairment derived from that system), dated 5/1/06
41. Neuro-surgical examination and report, dated 5/16/06
42. Four-view lumbar spine radiographs, with report, dated 5/31/06
43. Whole-body bone scan, dated 5/31/06
44. Operative report (lumbar facet radiofrequency neurolysis of the L3 and L4 sympathetic ganglia on the right, and right S1 transforaminal epidural steroid injections), dated 6/23/06
45. Operative report (multi-level provocative discography), dated 7/18/06
46. Post-operative CT scan, lumbar spine, dated 7/18/06
47. Operative report (total bilateral laminectomies at L3-4 and L4-5; bilateral medial facetectomies and foraminotomies at L3-4, L4-5; instrumentation with Synthes screws and bilateral connecting
48. rods at L3, L4 and L5; bilateral fusions at L3, L4, and L5 with BMP-2 and autografts), dated 8/24/06
49. Order for Required Medical Examination, dated 8/25/06
50. Physical therapy prescriptions
51. Counseling progress notes, multiple dates
52. Various administrative data regarding patient's Benefit Review Conference
53. Carrier "Peer Review – UM Referral Forms," multiple dates
54. Various hospital anesthesia, lab and pathology reports, multiple dates
55. Various DWC-73s

## CLINICAL HISTORY

Patient is a 49-year-old male member service representative for a major insurance company who, on \_\_\_\_, tried to get up out of a desk and when he moved upwards and rotated to his left, he felt and heard a loud "pop" in his lower back. (The claimant was positive for a previous history of lower back pain and subsequent lower back surgery in 1980). He reportedly experienced immediate lower back pain and was initially seen by his family physician who subsequently referred him to an orthopedic surgeon. Upon obtaining an MRI, the surgeon determined that an immediate lower back surgery was necessary, and it was performed later that same day on 7/9/04. When this was unsuccessful, he underwent a second surgery on 8/16/04, followed by post-surgical physical therapy and rehabilitation.

When these interventions still failed to provide significant relief, the claimant then underwent an extensive series of epidural steroid injections, sacroiliac joint injections and nerve blocks in late 2004 and early 2005. On 3/23/05, underwent yet another lower back surgical procedure where he had a spinal cord stimulator implanted in the region. On 6/23/05, lumbar facet radiofrequency neurolysis of the L3 and L4 sympathetic ganglia on the right, and right S1 transforaminal epidural steroid injections was then attempted with apparently less than desired results, including having developed RSD-type symptoms in his right lower extremity, and cauda equina-like symptoms, in terms of bladder incontinence, frequency and impotence; as a result, a multi-level discogram was ordered, followed by total bilateral laminectomies at L3-4 and L4-5; bilateral medial facetectomies and foraminotomies at L3-4, L4-5; instrumentation with Synthes screws and bilateral connecting rods at L3, L4 and L5; and bilateral fusions at L3, L4, and L5 with BMP-2 and autografts on 8/24/06.

REQUESTED SERVICE(S)

Office visits, levels II, III and IV (99212, 99213 and 99214), therapeutic exercises (97110)-GP, and unattended electrical stimulation (G0283) for dates of service 6/9/05 through 8/15/05. CPT 99080-73 for dates of service 08/12/05.

DECISION

Approve

RATIONALE/BASIS FOR DECISION

In this case, the medical records provided adequately reveal that a compensable injury occurred to this claimant's lower back, and that he was still receiving surgical interventions during the time frame in dispute. In addition, the treating doctor's notes sufficiently documented that the unattended electrical stimulation (G0283) and the therapeutic exercises (97110) fulfilled the statutory requirements<sup>1</sup> for medical necessity since the patient obtained relief from them. Furthermore, as the treating doctor, it was both medically necessary and prudent that he periodically see the patient, evaluate him, and coordinate all the care being rendered during that time. Therefore, the office visits (99212, 99213 and 99214) and CPT 99080-73 for dates of service 08/12/05 were also supported as medically necessary.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider 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 IRO.

## 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.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell