



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 Dispute

PART I: GENERAL INFORMATION

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

Requestor's Name and Address:
 Dr. Suhail Al-Sahli
 1210A Nasa Road 1
 Houston, Texas 77058

MDR Tracking No.: M5-07-0086-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
 Texas Mutual Insurance Company
 Rep Box # 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "This letter is to inform you that I am filing a Medical Dispute on Mr. ___ requesting payment from the Insurance Carrier – Texas Mutual Insurance Co.-for the total amount of \$4,250.00 over the period of August 22, 2005 – October 5, 2005. We have appealed to collect these charges from the insurance carrier, but the carrier has failed to provide us with proper explanation for not paying for these services."

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: The position statement submitted by Texas Mutual does not address the disputed services.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-16-05 to 10-05-05	97113-AT (1 unit @ \$41.13 X 8 units X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,316.16
	TOTAL DUE		\$1,316.16

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.

Dates of service 08-22-05 through 09-09-05 although listed on the Table of Disputed Services were per Rule 133.308(e)(1) untimely filed with Medical Dispute Resolution and therefore not eligible for review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)
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 \$1,316.16. 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:

Authorized Signature

Typed Name

11-16-06

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

November 10, 2006

Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MRD#: M5-07-0086-01
DWC#: _____
Injured Employee: _____
DOI: _____
IRO Certificate No.: IRO5317

Matutech, Inc., has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were obtained from NBC Healthcare Center, Inc. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in orthopedics and is currently on the DWC Approved Doctor list.

Sincerely,

John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by NBC Healthcare Center, Inc.:

Clinic notes (05/04/05 – 10/17/05)
Aquatic therapy notes (08/23/05 – 10/05/05)
Radiodiagnostic note (06/13/05)
Procedure note (07/13/05)
Designated doctor evaluation (12/28/05)

Clinical History:

This is a 42-year-old patient who fell approximately 8 feet from the top of a truck, landing heavily on his face and upper trunk. Since then, he experienced neck and upper thoracic spine pain. The pain radiated into both shoulders and the suboccipital area with numbness and tingling going into both hands.

On May 24, 2005, Richard Francis, M.D., noted that following the injury, the patient had been treated with physical therapy (PT) for two months consisting of electrical stimulation, heat, ultrasound, and stretching. Medications had been prescribed. X-rays of the cervical and lumbar spine performed in the office showed no significant abnormalities. A computerized tomography (CT) of the thoracic spine demonstrated a large, broad-based central T5-T6 calcified disc herniation with approximately 25% decrease in the anterior-posterior diameter of the spinal canal. Dr. Francis started the patient on Ultram, Flexeril and ibuprofen. Later, he added hydrocodone. In July, Jerry Keepers, M.D., administered a thoracic epidural steroid injection (ESI), and started the patient on Ambien, Vicodin, and Wellbutrin XL. From August 23, 2005 through October 5, 2005 the patient attended 10 sessions of aquatic therapy. In a designated doctor evaluation (DDE) in December 2005, Howard Douglas, M.D., assessed maximum medical improvement (MMI) as of December 28, 2005 and assigned 11% whole person impairment (WPI) rating.

Reimbursement for the aquatic therapy visits were denied by the carrier citing the following reasons: The services were non-covered services because they were not deemed "a medical necessity". The information submitted did not support this level of service, these many services, the length of service, dosage or supply.

Disputed Services:

Aquatic therapy (97113)

Explanation of Findings:

Based on the medical records provided, we are dealing with multiple body part injuries and a large broad based central T5-T6 Calcified disc herniation with approximately 25% decrease in AP diameter of the spinal canal. He had series of conservative treatment such

as epidural steroid injection(ESI) in conjunction with aquatic therapy in order to stabilize the thoracic spine with the MMI date as of 12/18/2005 and final impairment rating of 11% whole person .based on DD Doctor recommendation he could go back to work only on light duty.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overtturn denial:

Decision to Overturn. Based on severity of the injury, the aquatic Therapy (97113) was medically necessary.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

The documentation provided demonstrated that this patient had multiple body injuries. Since we were dealing with such a large thoracic Disc herniation and the patient decided not to have surgery (disc decompression), the aquatic therapy was medically necessary. This decision is made based on ACOEM and ODG treatment guidelines as well as clinical experience.

The physician providing this review is a DC, DACAN. The reviewer is national board certified in Chiropractic and Neurology. The reviewer is a member of American Chiropractic Academy of Neurology. The reviewer has been in active practice for 18 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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.