



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

Requestors Name and Address: Jaime Rivera, D. C 1642 E. Price Road, Suite 103 Brownsville, TX 78521	MDR Tracking No.: M5-07-0434-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: BOX 29	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "...some claims were submitted several times and we never received an EOB: some were resubmitted with out [sic] responses. And some were preauthorized and still no response or EOB's were received."

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

No Position Summary was submitted by the Respondent.

Principle Documentation:

1. EOB's

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)
7-19-04 – 10-18-04	98940 (\$31.35 x 20 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$627.00
7-19-04 – 9-13-04	97124-59 (\$26.28 x 19 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$499.32

7-19-04 – 9-13-04	97530-GP (\$34.65 x 35 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,212.75
9-1-04, 10-04-04	99215-25 (\$141.55 x 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$283.10
10-25-04 – 11-15-04	97110-GP (\$34.46 x 30 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,033.80
	Total Due		\$3,655.97

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) the amount due the Requestor for the items denied for medical necessity is \$3,655.97.

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 \$3,655.97. 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:

		02-23-07
_____ 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.

AMENDED January 30, 2007

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
512.804.4868

01/26/07

RE: IRO Case #: M5.07.0434.01
Name: _____
Coverage Type: Workers' Compensation Health Care - Non- network
Type of Review:
____ Preauthorization
____ Concurrent Review
XX Retrospective Review
Prevailing Party:
XX Requestor
____ Carrier

ZRC Medical Resolutions, Inc. (ZRC) has been certified, IRO Certificate #5340, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to ZRC for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

ZRC has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, ZRC reviewed the medical records and documentation provided to ZRC by involved parties.

This case was reviewed by a Doctor of Chiropractic, certified as a Peer Reviewer by National University of Health Sciences, also certified in manipulation under anesthesia. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of ZRC, I certify that:

1. there is no known conflict between the reviewer, ZRC and/or any officer/employee of ZRC with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 01/26/07.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.
President/CEO

**REVIEWER REPORT
M5.07.0434.01**

DATE OF REVIEW: 01/19/07

IRO CASE #: M5-07-0434-01

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

The services in dispute include CPT code 98940 for chiropractic manual treatment, 97124-59 for massage, 99215-25, an evaluation and management code, 97110-GP for therapeutic exercises, and 97530-GP for therapeutic activities.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

Approximately 78 pages of documents including but not limited to:

1. Twelve pages of TDI DWC-60 forms

2. Six pages of EOBs
3. Two pages of a peer review
4. Six pages from a URA called IMO
5. Three pages of an impairment rating report
6. Twenty pages of SOAP notes and daily notes from the chiropractic clinic
7. Approximately eighteen pages of records which included orthopedic, operative, and daily notes

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The employee was opening a closet door to clean it for painting when a box fell out of the closet, striking the lower calf, resulting in a contusion to the anterior tibial or fibular area. The case involves an employee who was struck in the knee for a compensable injury. The patient was seen by the attending physician and treated appropriately. It was thought the care was favorable with increased range of motion, decreased pain, and general overall improvement.

After a period of time, the insurance carrier denied medical necessity based upon a peer review report. The patient no longer returned to the chiropractic clinic at one point, and the compensable injury became worse, at which time he/she sought the services of an orthopedic surgeon. At that time, approximately 10/22/04, the patient was diagnosed with a left lateral meniscal tear. A surgical procedure was performed, a debridement of discoid lateral meniscus, debridement of a tear of the anterior horn of the medial meniscus, and partial synovectomy. At that point the orthopedic surgeon referred the patient back to the chiropractic clinic for post-surgical rehabilitation, which was also denied by the carrier inappropriately.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

I take issue with the initial peer review report as it does not seem to be complete in documenting the records which were reviewed. I do not feel that the patient's right to receive appropriate evaluation was denied. However, the Texas Labor Code section 408-021 states that a person is allowed to receive treatment that is appropriate for the relief or cure of a compensable injury or treatment that promotes recovery. This was further upheld in a Texas Appellate Court of Texarkana, citation Traveler's Insurance Company versus Vern, 2000 WL1052965 (Texas Appellate-Texarkana, 08/04/00), where one of the key holdings of the court stated, "Relief of symptoms creates a presumption of medical necessity."

Upon reviewing the 20-odd pages of SOAP notes, it was apparent that the patient was responding and improving under the treating physician's care. This falls in the guidelines of the definition of medical necessity. It was not until after the treatment by the physician was stopped due to denial from the insurance carrier that the patient experienced a remission to the point where they had to have surgery.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPR-Agency for Healthcare Research & Quality Guidelines.
- DWC-Division of Workers' Compensation Policies or Guidelines.
- European Guidelines for Management of Chronic Low Back Pain.
- Interqual Criteria.
- Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines:
 - My medical judgment based upon 26 years of clinical experience and expertise in accordance with accepted medical and chiropractic standards.