



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:

Pain and Recovery Clinics of Houston - South
P. O. Box 1984
Houston, Texas 77251

MDR Tracking No.:

M5-07-0555-01

Previous No.:

M4-05-B165-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

SERVICE LLOYDS INSURANCE CO, BOX 42

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Requestor did not submit a Position Summary.

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, "Please be advised that Gilbert and Maxwell have been retained to represent Pain and Recovery Clinics of Houston-South...regarding the aforementioned claim and Request for Medical Resolution."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. 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)
11-10-03	99080 (copy of records – 37 pages)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$18.50
12-10-03	99080-73	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$15.00
11-03-03 – 1-21-04	97032, 97140, 97110, 97112, E1399, 97750-FC, 99212, 99214	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$33.50

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. Per Rule 133.106(f)(3) copies of reports are reimbursed \$.50 per page. (\$.50 x 37 pages) The amount due the Requestor for the items denied for medical necessity is \$33.50.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5, 133.106, 133.308, 134.1.
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 Division has determined that the Requestor is not entitled to a refund of the IRO fee. The Requestor is entitled to additional reimbursement in the amount of \$33.50. 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

03-23-07

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.



Specialty Independent Review Organization, Inc.

Amended Report of 3/2/07

February 16, 2007

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: ____
MDR Tracking #: M5-07-0555-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The records received and reviewed indicated that Mr. ____ was injured in a work related accident on _____. Mr. ____ was working for _____ as a salesman when he was attempting to open a gate that was not working properly and injured his lower back with pain radiating to the left hip and left leg. The patient was later seen at the hospital for evaluation and management. Later the patient presented to Dr. Garner's office for care. An MRI was performed revealing disc injuries in the lumbar region. An EMG was also performed demonstrating left S1 radiculopathy.

RECORDS REVIEWED

Medical Dispute Resolution paperwork
Numerous EOB's
Request for Reconsideration from Dr. Garner dated 10-15-2003
Treatment notes from Pain & Recovery Clinic
Peer Review by Dr. Chamblin
Subsequent Medical reports by Dr. Garner
Representation Letter and Documentation by Gilbert & Maxwell
FCE by Optimum Medical Testing
Impairment Rating by Optimum Medical Testing
Letter from Harris & Harris
Report from Dr. Freeman
Letter from Corvel 10-7-2004

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of Electrical Stimulation 97032, Manual Therapy 97140, Therapeutic Exercises 97110, Neuromuscular Reeducation 97112, Special report 99080-73, Durable Medical Equipment E1399, Physical Performance Test 97750-FC, 99212 office visits, 99214 office visits and 99080 (copy of records) from 11/3/2003 through 1/21/2004.

DECISION

The reviewer agrees with the previous adverse determination regarding 97032, 97140, 97110, 97112, E1399, 97750, 99212 and 99214 for all dates under review.

The reviewer disagrees with the previous adverse determination regarding 99080 (copy of records) and 99080-73 for all dates under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, the Official Disability Guidelines, and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. The AMA CPT Code Book was also utilized in this determination. There is no documented necessity for the prolonged course of passive modalities and manual treatment measures and there is no explanation for the use of attended electrical stimulation. The documentation also does not provide sufficient reasoning for the durable medical equipment for the dates of service under review. The patient was provided numerous durable medical equipment supplies for home use in the beginning of care prior to the dates of service under review. DME's are generally provided for a patient to initiate a home program to decrease dependence on the provider or chronicity and to encourage a patient to participate in the recovery process. References are made in the both the carrier's and the doctor's documentation of the MRI and the EMG that was performed on the patient; however neither party supplied the testing. In fact, the documentation supplied on this patient is very limited in scope.

The MDA gives approximately 3 months for the duration of length of disability for this type of injury as identified below:

Lumbar Sprain/Strain

Duration in Days			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	3	7
Light	1	7	14
Medium	3	14	28
Heavy	7	21	42
Very Heavy	7	28	56

Lumbar Disc Injury Medical treatment

Duration in Days			
Job Classification	Minimum	Optimum	Maximum
Sedentary	1	7	14
Light	1	14	21
Medium	1	21	42
Heavy	1	56	91

Very Heavy	1	91	168
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Thus approximately 3 months of care would be clinically warranted if appropriately administered and documented. Any further care would need supporting rationale. The request for reconsideration letter provided by the treating doctor is dated prior to the dates of service under review and therefore does not explain the care under review. The efficacy of the treatment provided is not supported in the documentation.

REFERENCES

Medical Disability Advisor
Official Disability Guidelines
Evidence Based Medicine Guidelines
Medicare guidelines and payment policies
AMA CPT Code Book

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that 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.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the Division via facsimile, U.S. Postal Service or both on this 2nd day of March, 2007.

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli