

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Dr. Patrick R.E. Davis 115 W. Wheatland Road Suite 101 Duncanville, Texas 75116	MDR Tracking No.: M5-05-2235-01
	TWCC 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: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
04-15-04	05-30-04	99205, 98943, 97035, 97110, 97112, 97140, E0745 and E1399	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Code 97035 date of service 05-30-04 was withdrawn by the requestor on 05-16-05 and will not be a part of the review.

Code 99080-73 date of service 05-14-04 listed on the table of disputed services was paid by the carrier and is therefore no longer in dispute.

The Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

Authorized Signature

Typed Name

06-30-05

Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 29, 2005

To The Attention Of: TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker: _____
MDR Tracking #: M5-05-2235-01
IRO Certificate #: 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Initial examination report
- Daily notes
- Daily exercise logs

Submitted by Respondent:

- Peer reviews
- Remainder of the documentation from the carrier was dated 11/1/04 through 2/21/05 which was beyond the dates of service in question and was not needed for the review.

Clinical History

According to the supplied documentation, the claimant sustained an injury on ___ during the normal course and scope of his job. It appears the claimant injured his left shoulder when he was operating a crank on a trailer. The claimant was seen by Robert Grant, D.C. and began active and passive therapy protocols. On 4/15/04 the claimant presented to Patrick R. E. Davis, D.C. for evaluation. Dr. Davis diagnosed the claimant with a left shoulder internal derangement, left shoulder rotator cuff compromise, as well as pain and weakness. The treatment plan provided by Dr. Davis included a left shoulder injection by John Wey, M.D. on 5/5/04 with post injection therapy. The claimant underwent passive and active therapy protocols

during the dates of treatment in question. The documentation continues beyond the dates of service in question, but was not reviewed.

Requested Service(s)

99205 office visit, 98943 chiropractic manipulative treatment, 97035 ultrasound, 97110 therapeutic exercises, 97112 neuromuscular re-education, 97140 manual therapy technique, E0745 neuromuscular stimulator, E1399 TENS pads for electric muscle stimulator unit/out of clinic use for dates of service 4/15/04 through 5/30/04.

Decision

I agree with the carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the supplied objective documentation, the claimant had undergone approximately 31 chiropractic treatment sessions prior to his presentation to Dr. Davis. At that time, it should have been determined that conservative therapy had failed and other treatment options would be necessary. After careful review of the Official Disability Guidelines, all of the diagnoses that were listed in this particular case did not exceed the 31 treatments the claimant had already seen prior to the 4/15/04 presentation to the treating provider. Continued and ongoing passive and active therapies are not seen as reasonable or medically necessary to treat the compensable injury. Since the claimant received an adequate amount of conservative therapy, that failed, it would be necessary to change the treatment protocol. It would appear that the referral to the orthopedic surgeon would be a necessary and logical decision in the treatment of this claimant, while replicating previous treatments that failed would not seem medically necessary. After review of the disputed services, it would appear that none were clinically warranted to treat the compensable injury.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 29th day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder