



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	
Requestor's Name and Address:	MDR Tracking No.: M5-05-3040-01
Monarch Pain Care Center 5151 Katy Fwy, Suite 305 Houston, TX 77007	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary (Table of Disputed Services) states, "Medically Necessary."

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included DWC 60 form. Position summary states, "Harris & Harris represents Harris County in this matter... Thank you for your consideration."

#### 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)
2-14-05 – 4-29-05	CPT codes 97032, 97035, 97140, 97110, 97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,070.62

#### 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 amount due the requestor for the items denied for medical necessity is \$2,070.62.

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

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

**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 (\$650.00) 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 \$2,070.62. The Division hereby **ORDERS** the insurance carrier 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:

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

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

11-17-05

\_\_\_\_\_  
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.**

October 21, 2005

TDI, Division of Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-05-3040-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: IRO 5055

Dear :

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

I am the Secretary and General Counsel of Independent Review, Inc. and I certify 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 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 Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Physical Medicine and Rehabilitation and Pain Medicine, and is currently on the DWC Approved Doctor List.

#### 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 (other than a spinal surgery prospective 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,

Gilbert Prud'homme  
General Counsel  
GP:dd

## REVIEWER'S REPORT

M5-05-3040-01

### Information Provided for Review:

DWC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Office Notes & PT Notes 02/14/05 – 04/29/05

Information provided by Respondent:

Designated Review

Treating MD

### Clinical History:

The patient is a 32-year-old gentleman who was injured on \_\_\_ when he was a restrained driver in a vehicle that was T-boned on the driver's side. He was evaluated by his primary care physician and referred for physical therapy. When this failed to improve his status, he was referred to an orthopedist who ordered further physical therapy. Ultimately he was released to work without restriction on 05/06/05.

### Disputed Services:

Services including electrical stimulation, ultrasound, manual therapy technique, therapeutic exercises, and therapeutic activities were questioned regarding medical necessity ranging from 02/14/05 through 04/29/05.

### Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion the services in dispute as stated above were medically necessary in this case.

### Rationale:

The therapeutic interventions provided were appropriate for the injury the patient sustained. Both the participatory therapies as well as the modality therapies were entirely appropriate. The length of time over which these were given, while somewhat longer than usual, was well within an acceptable range, given the documentation of the patient's progress.

### SCREENING CRITERIA/TREATMENT GUIDELINES UTILIZED:

The accepted national standards of care and treatment guidelines were referred to in forming my opinion.