



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Monarch Pain Care Center 5151 Katy Freeway Suite 305 Houston, Texas 77007	MDR Tracking No.: M5-05-3075-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Service Lloyds Insurance Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: TWCC-60 package, CMS 1500s, explanations of benefits and medical documentation  
POSITION SUMMARY: "Medically necessary" per the table of disputed services

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

DOCUMENTATION SUBMITTED: Response to TWCC-60  
POSITION SUMMARY: Respondent did not submit a position summary

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-25-04 to 09-17-04	97001, 97110, 97032, 97035, 97530, 97112 and 97002	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

#### 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.

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

28 Texas Administrative Code Sec. 133.308

**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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

**Findings and Decision by:**

10-19-05

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

\_\_\_\_\_  
Date of Findings and Decision

**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.**



CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:**

**Texas IRO # :**

**MDR #:** M5-05-3075-01

**Social Security #:**

**Treating Provider:** Monarch Pain Care Center

**Review:** Chart

**State:** TX

**Review Data:**

- Notification of IRO Assignment dated 9/16/05, 1 page.
- Receipt of Request dated 9/15/05, 1 page.
- Medical Dispute Resolution Request/Response dated 7/21/05, 1 page.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputed Services dated 9/17/04, 9/15/04, 9/13/04, 9/10/04, 9/8/04, 9/7/04, 9/3/04, 9/1/04, 8/30/04, 8/27/04, 8/25/04, 3 pages.
- Facsimile dated 9/20/05, 1 page. (3 copies)
- Fax Confirmation Sheet dated 9/20/05, 3 pages.
- Review Audit dated 3/25/05, 3/24/05, 10/2/04, 9/22/04, 9 pages.
- Fax Cover Sheet dated 9/28/05, 1 page.
- Legal Letter dated 9/27/05, 2 pages.
- Designated Doctor Summary (date unspecified), 6 pages.
- Payment of Compensation or Notice of Refused/Disputed Claim dated 11/17/03, 1 page.
- Daily Note (date unspecified), 1 page.
- Case Review dated 10/27/03, 5/26/04, 5 pages.
- Report of Medical Evaluation dated 5/24/04, 1 page.
- Narrative Report dated 5/6/04, 5 pages.
- Independent Medical Examination dated 4/15/04, 5 pages.
- Summary of Retrospective/Concurrent Review dated 10/27/03, 1 page.
- Case Review by Chiropractor dated 10/24/03, 9 pages.
- Lumbar Spine MRI dated 8/25/03, 2 pages.
- Letter From Monarch Pain Care and Rehabilitation Center dated 10/13/04, 1 page.
- Physical Therapy Documentation and Procedure dated 9/17/04, 9/15/04, 9/13/04, 9/10/04, 9/8/04, 9/7/04, 9/3/04, 9/1/04, 8/30/04, 8/27/04, 8/25/04, 11 pages.
- Initial Evaluation dated 8/25/04, 3 pages.
- Request for Reconsideration dated 3/3/05, 1 page.
- Physical Therapy Re-evaluation dated 9/15/04, 2 pages.
- Health Insurance Claim Forms dated 9/21/04, 9/15/04, 9/8/01, 9/1/04, 7 pages.
- Order for Payment of Independent Review Organization Fee dated 9/30/05, 1 page.
- Invoice dated 9/19/05, 1 page.

**Reason for Assignment by TDI:** Appeal the medical necessity of the previously denied request for physical therapy evaluation, therapeutic exercises, electrical stimulation, ultrasound, therapeutic activities, neuromuscular re-education, and physical therapy re-evaluation from 8/25/04 to 9/17/04.

**Determination: UPHELD** - previously denied request for physical therapy evaluation, therapeutic exercises, electrical stimulation, ultrasound, therapeutic activities, neuromuscular re-education, and physical therapy re-evaluation from 8/25/04 to 9/17/04.

**Rationale:**

Injured worker's age: **50 years.**

Gender: **Male.**

Date of Injury: \_\_\_\_.

Mechanism of Injury: **Fell while cleaning the roof of a vehicle.**

**Diagnoses:** Lumbar strain/sprain, internal derangement right knee, status post medial and lateral meniscectomy and ACL reconstruction with anterior tibialis allograft, and right ankle strain.

Based on a review of the clinical documents provided, physical therapy for date of service August 25, 2004 through September 17, 2004 is not recommended as medically necessary. More specifically, since the time of the injury, the claimant had been placed at maximum medical improvement on May 6, 2004. The diagnosis was rendered of a medial and lateral meniscal tear and repair of anterior cruciate ligament (ACL) reconstruction of the knee. This was done on September 17, 2003, and a lumbar strain with spondylolisthesis grade 1, which in this reviewer's opinion, was a pre-existing condition. As well, after the date of injury of \_\_\_, the claimant underwent 57 visits under the auspices of Brenda, D.C., chiropractor.

The patient underwent a series of office visits, diagnostic studies, prescriptions, medications, referral, physical therapy, chiropractic manipulations, spinal injections, anesthesiology, procedures, pain management, surgeries, and durable medical equipment. The claimant had undergone adequate, if not thorough, physical therapy treatments for a prolonged period of time. Generally speaking, for a knee injury, anywhere from three months to four months would be maximal amount of time needed for even in ACL reconstruction.

Regarding the back, there appeared to be some underlying pre-existing problem, however, the claimant was injured on \_\_\_ and three months duration of therapy should be adequate. Certainly the dates seemed to fall not within the normal period of time for recovery. The claimant underwent a series of diagnostic studies of the right knee dated July 12, 2003, which revealed no evidence of fracture. X-ray of the lumbar spine on July 14, 2002 revealed decreased disk space and spondylolisthesis at L5. X-rays of the right ankle were normal. MRI of the right knee dated August 1, 2003 revealed a complete ACL tear with joint effusion and bone contusion involving a lateral tibial condyle and medial meniscal tear in the lateral meniscus. An MRI of the lumbar spine on August 25, 2003 revealed a L5-S1 grade I spondylolisthesis with slippage measuring approximately 8 mm.

The claimant had a history of a motor vehicle accident approximately eight years ago. On examination, the claimant was noted to have a positive Lachman's sign by Dr. Mattahd, and then underwent a surgery for this condition. The patient also underwent a peer review on October 10, 2003 by Dr. Brian Buck, a physical medicine and rehabilitation doctor. Dr. Buck noted that the claimant would need about eight weeks of progressive rehabilitation and a home exercise program. It was also noted that a bone scan was done and showed no evidence of an acute injury to the low back, suggestive that this was an old injury and not a new injury.

Another review by Dr. Mark Sanders felt that the back was related to its developmental rather than traumatic nature. The bottom line is that, although this patient did have an injury related to a compensable Workers' Compensation injury, the therapy that was indicated from August 25, 2004 through September 17, 2004 is beyond the scope of a type of injury that this claimant would have had. Also of note, was that the patient was on Skelaxin and Bextra and had no prior histories. He is married and does not smoke or drink.

**Criteria/Guidelines utilized:** Official Disability Guidelines, 9<sup>th</sup> Edition, Special Edition, 2004.

**Physician Reviewers Specialty:** Physical Medicine & Rehabilitation/Pain Management

**Physician Reviewers Qualifications:** Texas licensed MD, and currently listed on the TWCC ADL list.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified 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 determination prior to referral to CompPartners, Inc.**

**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.