



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:	MDR Tracking No.: M5-05-3322-01
Todd L Bear DC 12619 East Frwy Ste A Houston TX 77015	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
St Paul Fire & Marine Insurance Box 05	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package, EOBs, CMS-1500s. Position Summary as stated on the table of disputed services – office visit discuss pts progress and post op. therapy per [surgeon's] orders.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 response. Position Summary – The carrier disputes that the provider has shown that the treatment underlying the charges was medically necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. Further, the documentation provided does not establish medical necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
8-23-04 to 9-1-04	99211 (MAR is \$18.00 x 4 days = \$72.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 72.00
	99213 (MAR is \$48.00 x 1 day = \$48.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 48.00
	97032 (MAR is \$20.04 x 5 days = \$100.20)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$100.20
	97035 (MAR is \$15.78 x 5 days = \$78.90)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 78.90
	97110 (MAR is \$35.00 x 5 days = \$175.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$175.00
	TOTAL		\$474.10

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 disputed dates of service 8-16-04 through 8-20-04 are untimely and ineligible for review per Rule 133.308(e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Division no later than one year after the dates of service in dispute.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: DIVISION DECISION AND ORDER

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 entitled to additional reimbursement in the amount of \$474.10. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. 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.

Ordered by:

Medical Dispute Officer

11-15-05

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-05-3322-01
NAME OF REQUESTOR: Todd L. Bear, D.C.
NAME OF PROVIDER: Todd L. Bear, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 11/02/05

Dear Dr. Bear:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, 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.

REVIEWER REPORT

Information Provided for Review:

Evaluations with Esteban N. Berberian, M.D. dated 02/07/03, 03/28/03, 07/15/03, and 07/28/03
Laboratory studies dated 02/07/03
X-rays and an MRI of the left knee interpreted by Edward Knudson, M.D. dated 07/21/03

An evaluation with Abiel Garcia, M.D. dated 07/28/03
An evaluation with E. Brooke Roberts, M.D. dated 07/29/03
Operative reports from Leland Winston, M.D. dated 08/08/03 and 08/06/04
A prescription for physical therapy from Dr. Winston dated 08/18/03
Evaluations by Ramiro Torres, D.C. dated 08/19/03, 09/16/03, 12/12/03, and 01/13/04
Chiropractic treatment with Dr. Torres dated 08/19/03, 08/20/03, 08/22/03, 08/25/03, 08/27/03, 08/29/03, 09/04/03, 09/05/03, 09/08/03, 09/10/03, 09/12/03, 09/16/03, 09/17/03, 09/18/03, 09/22/03, 09/24/03, 09/26/03, 09/29/03, 10/01/03, 10/02/03, 10/06/03, 10/07/03, 10/08/03, 10/09/03, 10/13/03, 10/14/03, 12/12/03, 12/18/03, 12/30/03, 01/02/04, 01/06/04, 01/12/04, 01/13/04, 01/15/04, 01/19/04, 01/28/04, and 02/02/04
Physical therapy notes with Clay Meekins, L.P.T. dated 09/18/03 and 12/16/03
Evaluations with Dr. Winston on 10/15/03, 12/03/03, 07/21/04, and 02/03/05
An EMG/NCV study interpreted by Robert Lowry, M.D. dated 10/30/03
Continuance claim forms for additional treatment from Dr. Torres dated 01/16/04 and 02/10/04
A letter written by Dr. Berberian dated 02/17/04
An MRI of the left knee interpreted by Allan D. Ahlschier, M.D. dated 05/21/04
A Designated Doctor Evaluation with William M. Granberry, M.D. dated 06/15/04
A letter from Concentra Integrated Services dated 10/05/04
A mental health assessment with Monie G. Smith, M.A., L.M.F.T. dated 10/07/04
A vocational assessment report with Phillip W. Roddy, M.S., C.R.C. dated 10/07/04
An evaluation with Jeremiah J. Twomey, M.D. dated 11/10/04
A letter from Dr. Granberry dated 04/14/05
A letter from S. Rhett Robinson at Flahive, Ogden, and Latson, Attorneys at Law, dated 09/12/05

Clinical History Summarized:

Dr. Berberian recommended surgery on 02/07/03. An MRI of the left knee interpreted by Dr. Knudson on 07/21/03 revealed a posterior horn medial meniscus tear, osteochondritis dissecans of both femoral condyles, and a moderate joint effusion. Dr. Garcia felt the claimant had a preexisting condition on 07/28/03 and recommended an orthopedic evaluation. A left knee arthroscopy with medial meniscus debridement was performed by Dr. Winston on 08/08/03. Chiropractic therapy was performed with Dr. Torres from 08/19/03 through 02/02/04 for a total of 37 sessions. An EMG/NCV study interpreted by Dr. Lowry on 10/30/03 revealed moderate right carpal tunnel syndrome. On 12/03/03, Dr. Winston felt the claimant was at Maximum Medical Improvement (MMI) with a 1% whole person impairment rating and could return to full work duty. An MRI of the left knee interpreted by Dr. Ahlschier on 05/21/04 revealed chondromalacia, patellar subluxation, a small effusion, an MCL strain, and a probable tear in the medial meniscus. Dr. Granberry's evaluation on 06/15/04 stated he agreed with the date of MMI and impairment rating. Dr. Winston performed a left knee arthroscopy, chondroplasty, and loose body removal on 08/06/04. On 10/05/04, Concentra Integrated Services provided a letter of denial for a work hardening program, a Functional Capacity Evaluation (FCE), and 12 physical therapy sessions for the left knee. On 11/10/04, Dr. Twomey felt the claimant's osteochondritis dissecans was a condition of life and was not related to the ___ injury. On 02/03/05, Dr. Winston felt the osteochondritis dissecans was caused by the claimant's work duty and the second surgery was necessary due to continued symptoms from the same process. On 04/14/05, Dr. Granberry felt the claimant's surgery was not made necessary by the original injury and that the date of MMI and impairment rating would be unchanged. On 09/12/05, Mr. Robinson from Flahive, Ogden and Latson Attorneys at Law stated a Medical Dispute Resolution (MDR) had been requested.

Disputed Services:

Office visits, electrical stimulation, ultrasound, and therapeutic exercises from 08/23/04 through 09/01/04

Decision:

I agree with the requestor. The office visits, electrical stimulation, ultrasound, and therapeutic exercises from 08/23/04 through 09/01/04 were reasonable and necessary.

Rationale/Basis for Decision:

The question should be whether the treatment provided to the claimant satisfies the sections of qualifications of Section 4408.021 of which the Texas Labor Code, which only substantiates that need for naturally resulting care, which (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retrain employment. Based upon review of the medical documentation, the treatment provided from 08/23/04 through 09/01/04 was reasonable and necessary. There appeared to be a question regarding whether or not the second surgery was related to the need for the second surgery and to the injury of _____. That determination would not be mine to make. Regardless of whether the second surgical intervention was necessary or related to the original injury, the treatment provided from 08/23/04 through 09/01/04 would be medically reasonable and necessary regarding any postsurgical situation. Obviously, if the second surgery was determined not to be related to the original injury, then the compensability of the treatment provided from 08/23/04 through 09/01/04 would not be established. The treatment provided does satisfy the requirements and qualifications of Section 408.021 and, therefore, would be medically reasonable and necessary.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 11/02/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel