



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

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:
 Health & Medical Practice Associates
 324 North 23rd Street, Suite 201
 Beaumont, Texas 77707

MDR Tracking No.: M5-06-0247-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:
 Texas Mutual Insurance Company
 Box 54

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC package
 POSITION SUMMARY: Per table of disputed services "medically necessary"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC package filed by Requestor
 POSITION SUMMARY: "Therefore, Texas Mutual requests that the request for dispute resolution filed by Health & Medical Practice Assoc, be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-12-05 to 06-29-05	97032, 97035 and 97140	<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:

Authorized Signature

12-06-05

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0247-01
Name of Patient:	
Name of URA/Payer:	Health & Medical Practice Associates
Name of Provider: (ER, Hospital, or Other Facility)	Health & Medical Practice Associates
Name of Physician: (Treating or Requesting)	Patrick McMeans, MD

November 28, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him 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 MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

CLINICAL HISTORY

Medical Records Reviewed

1. Explanation of benefits from Texas Mutual
2. Information packet from Health and Medical Practice Associates
3. Progress notes from Patrick McMeans, M.D.
4. Excerpts from texts and rules
5. Ultrasound (echoic) study from Alex Kalliakin, D.C.

This is a 28 year old gentleman who was struck on the left elbow while at his place of employment. This was diagnosed by Dr. McMeans as "unspecified strain/sprain and muscle spasm". Radiographs were reported as normal. This initial treatment was with ultrasound applications. One week later this was followed with "joint mobilization" (for the elbow that had a nearly full range of motion) and therapeutic exercise. In the first two weeks of treatment, (May 4 – May 17) the complaints of pain were unchanged, noted to be the "same". Mr. _____ was continued in an off work status for this elbow contusion. The symptoms were reported as mild pain and stiffness in the elbow on _____ . This level of complaint continued through June 30.

REQUESTED SERVICE(S)

Medical necessity for 97032 Electrical stimulation; 97035 Ultrasound; and 97140 Manual Therapy for dates of service 5/12/05 through 6/29/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

As noted in the ACOEM Guides, in the absence of "red flags" primary treating providers can manage this type of injury with a modified duty

and return to work within 7 days. There is no indication for any physical therapy modalities. Treatment is based on decreasing activities, immobilization (if warranted) and non-prescription analgesics. As per the ODG, a return to work with modified duty is warranted. There is no indication to keep off work. Non-steroidal, anti-inflammatory medications (over the counter) plus some physical therapy. As with any treatment, if there is no improvement after 2 weeks the protocol may be modified or re-evaluated. (Piligian, 2000) (Boyer, 1999) (Sevier, 1999) (Foley, 1993) (Struijs, 2004) A recent meta analysis to evaluate the available evidence of the effectiveness of physical therapy for lateral epicondylitis of the elbow, concluded that the pooled estimate of the treatment effects of studies on ultrasound compared to placebo ultrasound, showed statistically significant and clinically relevant differences in favor of ultrasound. Women and patients who report nerve symptoms are more likely to experience a poorer short-term outcome after PT management of lateral epicondylitis. A recent clinical trial found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004). Lastly as noted in Wheelless Text of Orthopedics, the initial treatment for such a diagnosis would be rest. Thus the physical therapy modalities implemented were not clinically indicated.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of November, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell