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.: M5-06-0470-01
Main Rehab & Diagnostics/Administrative Office **3500 Oak Lawn Suite 380** **Dallas TX 75219**	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
Texas Mutual Insurance Box 54	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: Necessary office visit/treatment.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: Carrier requests that the request for dispute resolution be conducted under the provisions of the APA.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
3-30-05 to 8-29-05	99211 $26.25 (less than MAR) x 6 days = $157.50 97110 $34.93 (MAR) per unit x 82 units = $2864.26 97530 $36.11 (less than MAR) x 17 units = $613.87	☒ **Yes** ☐ **No**	$3,635.63
6-14-05	95831-59	☐ **Yes** ☒ **No**	$0.00
	Total		$3,635.63

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 **prevailed** on the majority of 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 $3,635.63. 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	1-30-06
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.

P-IRO

An Independent Review Organization
7626 Parkview Circle
Austin, Texas 78731
Phone: 512-346-5040
Fax: 512-692-2924

December 28, 2005

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868 Delivered via Fax

Patient / Injured Employee ___
TDI-DWC # ___
MDR Tracking #: M5-06-0470-01
IRO #: 5312

P-IRO, Inc. has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI-Division of Worker's Compensation (DWC) has assigned this case to P-IRO for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

P-IRO has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Provider board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL). The P-IRO Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer 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 carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO assignment, information provided by The Requestor, Respondent, and Treating Doctor(s), including: Texas Mutual carrier statement dated 12-14-2005, notification of IRO assignment, TWCC-60, Concentra Medical SOAP 8-19-2004, Main Rehabilitation & Diagnostic Center initial 9-14-2004, Berkshire Medical Services initial 9-15-2004, MRI cervical dated 10-12-2004, MRI shoulder dated 10-12-2004, Main Rehabilitation & Diagnostic Center re-evaluation 10-14-2004, Texas Bone & Joint report 11-01-2004, 11-24-2004, 12-07-2004, 12-27-2004, 1-26-2004, 2-09-2005, 2-28-2005, 3-11-2005, 4-27-2005, 5-18-2005, 5-25-2005, 6-08-2005, 6-22-2005, 7-11-2005, 8-10-2005, 10-21-2005, Irving Surgery Center 3-08-05, 6-14-2005, Main Rehabilitation & Diagnostic Center office SOAP 3-30-2005, 4-22-2005, 5-04-2005, 5-31-2005, 6-09-2005, 6-23-2005, 7-13-2005, 7-25-2005, 7-27-2005, 8-11-2005, 8-12-2005, 8-22-2005, 8-29-2005, ROM test 6-02-2005, 6-28-2005, 7-11-2005, Follow-up report Charles Willis MD dated 6-23-2005, 8-04-2005, Texas Designated Doctor report 8-17-2005, EOB DOS 3-4-05, 4-22-05, 5-04-05, 5-09-05, 5-10-05, 5-12-05, 5-17-05, 5-18-05, 6-14-05, 7-13-05, 7-18-05, 8-11-05, 8-28-05, 8-29-05, FCE 4-06-2005, 8-31-2005, 9-01-2005, Radiographic report Texas Bone & Joint Center 11-01-04, Texas Bone & Joint Center script 2 different dates not readable and an additional on 7-11-2005.

CLINICAL HISTORY

The Patient sustained a work related injury on ___, when he slipped on a flight of stairs and injured his neck and left shoulder. He was initially seen by Concentra Medical Center. He eventually fell under the care of Osler Kamath DC, who performed physical modalities and made several referrals. MRI of the cervical spine dated 10-12-2004 revealed a C5-6 left annular disc bulge with mild left C6 neural foraminal narrowing and straightening of the cervical lordosis. MRI of the left shoulder dated 10-12-2004 revealed mild tendonitis and possible impingement. The Patient had several weeks of physical modalities with Dr. Kamath. The Patient was referred to Texas Bone & Joint Center for an orthopedic examination and eventually on 3-08-2005 underwent a left partial rotator cuff repair and distal clavicular resection/modified Mumford procedure with

Acromioplasty. The Patient had post-operative therapy that started back on 4-07-2005. ROM/muscle testing was performed throughout and revealed consisted improvement. The Patient had several CESI and a MUAP to the left shoulder. On 8-17-2005, The Patient was assessed at MMI and was assigned a 15% impairment rating, by Dr. Nachimson, MD.

DISPUTED SERVICE (S)

Under dispute is the retrospective medical necessity of 97530-QU-GP-Therapeutic Activity, 97110-QU-GP-Therapeutic Exercises, 95831-QU-GP-Muscle Testing for the dates 3-30-2005 through 8-29-2005.

DETERMINATION / DECISION

The Reviewer partially agrees with the determination of the insurance carrier in this case. The Reviewer agrees with the insurance carrier on the following: DOS 6-14-2005 is not medically necessary; the Reviewer disagrees with insurance carrier on the following: all other services listed in the dispute are reasonable and necessary.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, the Reviewer concluded that the disputed services were medically necessary. On 3-08-05, The Patient underwent a left shoulder operation and was not released for therapy by the surgeon until 4-07-05. The Patient developed some adhesions/restriction and therefore underwent a left shoulder MUA. This was followed by several weeks of post-op therapy. Clinical documentation did support that The Patient did progress during the disputed time frames and was eventually assessed at MMI and assigned an impairment rating. Additionally, other providers supported the medical necessity throughout care. This was further backed up by the DWC Designated Doctor examination.

Screening Criteria

1. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

P-IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. P-IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of P-IRO Inc., I certify that there is no known conflict between the Reviewer, P-IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

P-IRO is forwarding by mail or facsimile, a copy of this finding to the DWC.

Sincerely,
P-IRO Inc.

Ashton Prejean
President & Chief Resolutions Officer

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.

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

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, U.S. Postal Service or both on this 28th day of December, 2005.

Name and Signature of P-IRO Representative:

Sincerely,
P-IRO Inc.
Ashton Prejean
Ashton Prejean
President & Chief Resolutions Officer