



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

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Pride 5701 Maple Avenue, Suite #100 Dallas, Texas 75235	MDR Tracking No.: M5-06-0527-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rochdale Ins Company, Box 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 form, Explanations of Benefits and CMS 1500's. Position summary states, "The peer review stated that 6-12 sessions of physical therapy would be all that would be reasonably justified. The patient was seen for 8 sessions of physical therapy and 6 out of the 8 were denied."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response and peer reviews. Position summary states, "The peer review indicated that 6 – 12 visits of therapy, post-injury, would be reasonable, but not mandatory. The requestor interpreted the reviewer's statement to mean that any number of therapy visits, up to the mentioned 12 visits, regardless of the dates, would be considered reasonable."

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)
6-21-05 – 9-6-05 (except 7-14-05)	CPT codes 99213-25, 97530, 90782, J1100, J2001, J1000, 20552	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$625.20
7-14-05	CPT code 97530	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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 majority of the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$625.20.

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 \$625.20. 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:

Donna Auby

12-22-05

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.



Specialty Independent Review Organization, Inc.

December 13, 2005

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient: ____
DWC #: ____
MDR Tracking #: M5-06-0527-01
IRO #: 5284

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

Specialty IRO has performed an independent review of the care rendered 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.

This case was reviewed by a licensed Doctor of Osteopathy with a specialty in Orthopedics. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This 49-year-old female was injured on ____ after repetitive injury to the right shoulder and right wrist after having lifted a desk drawer 3-4 times to place it back on track. The patient has a past medical history of bilateral wrist injury in ____ with a left carpal tunnel release.

The physical examination revealed tenderness in the parascapular area in the region of the rhomboids at the medial margin of the scapula associated with pain on stretching and shoulder pronation. Patient has a large trigger area in the rhomboid.

The patient received physical therapy and reached MMI. Approximately 6 weeks after the MMI the patient had recurrent symptoms in the right rhomboid. The treatment was ice, stretching, postural corrections, and short period of rest while performing work activity. The patient did not respond to this initial care and received two trigger point injections in the right rhomboid.

RECORDS REVIEWED

Records from Carrier:

Amtrust, Letter: 11/16/2005.
Pride, Letter: 10/31/2005.
M Tonn MD, Letter: 5/02/2005.
T Mayer MD, Letter: 7/28/2005.

Records from Doctors/ Facility:

T Mayer MD, Reports: 3/10 through 12/05/2005.

Pride Letter: 12/06/2005.

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of office visits-99213-25, therapeutic activities-97530, therapeutic/prophylactic or diagnostic injection-90782, injection-dexamethasone sodium phosphate 1mg-J1100, injection-lidocaine HCL for intravenous infusion 10mg-J2001, injection depo-estradiol cypionate up to 5mg-J1000, injection single or multiple trigger points 1 or 2 muscles-20552 from 6-21-2005 through 10-18-2005.

DECISION

The reviewer disagrees with the previous adverse determination regarding 99213 and 99225 on 06/21/2005 Office Visit; 97530 on 06/21/2005 Therapeutic Activities; 90782 on 10/21/2005 Injection; J1100 on 06/21/2005 Injection of Dexamethasone Sodium Phosphate 1 mg; 97530 on 06/27, 6/30, 7/05, 7/13, and 7/20/2005; 99213 and 99225 on 09/06/2005 Office Visit; 20522 on 09/6/2005 Trigger Point; J2001 Lydocaine HCL Infusion; J1000 on 09/06/2005 Injection of Depo-Estradiol Cypionate up to 5 mg.

The reviewer agrees with the previous adverse determination regarding 97530 Therapeutic Activities on 07/14/2005.

BASIS FOR THE DECISION

The reviewer states that this patient has reoccurrence of the rhomboid spasm following her MMI that required medical treatment. Two trigger point injections are well within the standard of care. Six physical therapy sessions would be reasonable and justified coupled with the appropriate instructions for the use of home modalities, a home program of exercise, stretching, and strain counter-strain. Over the counter analgesics may be beneficial. The approved care is within the standard of care. The denial of the therapeutic activities on 07/14/2005 is because the same activities were administered on 07/13/2005.

Travell and Simons: MYOFASCIAL PAIN & DYSFUNCTION, The Trigger Point Manual.

Brotzman & Wilk: CLINICAL ORTHOPEDIC REHABILITATION, 2nd Edition.

Lennard: PAIN PROCEDURES AND CLINICAL PRACTICE.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that 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.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

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,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the via facsimile, U.S. Postal Service or both on this 13th day of December 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli