



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: Bandera Road Injury Center 6831 Bandera Road Leon Valley, Texas 78238	MDR Tracking No.: M5-06-0690-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-29-05 to 04-21-05	97124 (1 unit @ \$26.63 X 8 = \$213.04) G0283 (1 unit @ \$13.61 X 10 = \$136.10) 97110 (1 unit @ \$33.56 X 27 = \$906.12) 97140-59 (1 unit @ \$31.79 X 2 = \$63.58) 99213-25 (not in dispute during timeframe = \$0.00) 99214-25 (not in dispute during timeframe = \$0.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,318.84
04-22-05 to 07-11-05	97124, G0283, 97110, 97140-59, 97750-FC, 99213-25 and 99214-25	<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 majority of the disputed medical necessity issues.

The Requestor submitted an updated table of disputed services on 01-03-06 which was used for the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)

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 reimbursement in the amount of \$1,318.84. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

02-17-06

Authorized Signature

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: M5-06-0690-01
NAME OF REQUESTOR: Bandera Road Injury Center
NAME OF PROVIDER: Kimberly Driggers, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 01/31/06

Dear Bandera Road Injury Center:

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:

An Employer's First Report of Injury or Illness dated
Evaluations with an unknown provider (no name or signature was provided) at Alamo City Medical Group dated 01/27/05, 02/04/05, 02/09/05, 02/10/05, and 02/17/05
A job offer dated 02/17/05
An evaluation with Victor I. Lyday, M.D. dated 02/23/05
An evaluation with Kimberly S. Driggers, D.C. dated 02/24/05
Chiropractic treatment with Dr. Driggers dated 02/24/05, 02/25/05, 02/28/05, 03/01/05, 03/04/05, 03/07/05, 03/08/05, 03/09/05, 03/16/05, 03/17/05, 03/18/05, 03/21/05, 03/23/05, 03/29/05, 03/30/05, 03/31/05, 04/04/05, 04/05/05, 04/06/05, 04/11/05, 04/13/05,

04/15/05, 04/18/05, 04/20/05, 04/21/05, 04/25/05, 04/26/05, 04/28/05, 05/02/05, 05/04/05, 05/06/05, 05/09/05, 05/11/05, 05/13/05, 05/16/05, 05/17/05, 05/18/05, 05/19/05, 05/23/05, 05/25/05, 05/26/05, 05/31/05, 06/06/05, 06/07/05, 06/15/05, 06/16/05, 06/20/05, 06/23/05, 06/24/05, 06/29/05, 06/30/05, 07/06/05, 07/08/05, 07/25/05, 08/07/05, 08/15/05, 08/25/05, 08/31/05, 09/01/05, 09/10/05, 09/29/05, 10/04/05, 10/18/05, 10/27/05, 11/02/05, 11/16/05, 11/29/05, 12/06/05, and 12/14/05

Notices of Disputed Issue(s) and Refusal To Pay Benefits Forms dated 02/25/05 and 06/17/05

An MRI of the left wrist interpreted by Jose L. Arbona, M.D. dated 02/28/05

Letters written "To Whom It May Concern" from Dr. Driggers dated 03/08/05, 04/26/05, and 05/10/05

TWCC-73 forms from Dr. Driggers dated 03/09/05, 03/28/05, 04/11/05, 04/25/05, 05/09/05, 05/23/05, 06/06/05, 06/20/05, 07/06/05, 07/19/05, 07/27/05, 08/17/05, 09/13/05, 10/11/05, 11/09/05, and 12/15/05

An EMG/NCV study interpreted by Meyer L. Proler, M.D. dated 03/11/05

Evaluations with Mark A. Katz, M.D. dated 03/22/05 and 10/06/05

Evaluations with S. Ali Mohamed, M.D. and Rolando F. Rodriguez, M.D. dated 03/23/05, 04/13/05, 05/04/05, 05/25/05, 06/17/05, 07/15/05, 08/12/05, and 09/30/05

An evaluation with an unknown provider (the signature was illegible) at Christus Santa Rosa emergency room dated 03/31/05

An evaluation with an unknown provider (no name or signature was provided) dated 04/25/05

A Required Medical Evaluation (RME) and Functional Capacity Evaluation (FCE) with Marc T. Taylor, M.D. dated 04/28/05

An FCE with Dr. Driggers dated 05/16/05

An evaluation with Terry L. Westfield, M.D. dated 06/09/05

An undated Decision and Order letter from Alan C. Ernst, Hearing Officer at Texas Workers' Compensation Commission (TWCC)

A Designated Doctor Evaluation with Richard J. Stephenson, D.C. dated 07/08/05

Evaluations with an unknown provider (no name or signature was available) at South Texas Center for Orthopedics dated 07/11/05, 07/27/05, 08/17/05, 08/17/05, and 09/07/05

A letter written to Dr. Stephenson from the patient's insurance carrier dated 08/09/05

A Notification of Reinstatement of Indemnity Benefit Payment form from the insurance carrier dated 08/16/05

A Response Letter to the insurance carrier from Dr. Stephenson dated 09/22/05

A letter of medical necessity from Elliott I. Clemence, M.D. dated 10/12/05

An EMG/NCV study interpreted by C. Truett, M.D. dated 10/25/05

Clinical History Summarized:

On 02/23/05, Dr. Lyday recommended desensitization techniques and a functional wrist brace. Chiropractic treatment was performed with Dr. Driggers from 02/24/05 through 12/14/05 for a total of 69 sessions. An MRI of the left wrist interpreted by Dr. Arbona on 02/28/05 revealed partial disruption of the scaphoid attachment of the ligament and a small subcortical cyst in the dorsal aspect of the lunate. Dr. Katz recommended a thumb spica splint on 03/22/05. On 04/13/05, Dr. Mohamed recommended continued physical therapy, wrist splinting, Vicodin, Lodine, and a topical gel. An FCE with Dr. Driggers on 05/16/05 showed the patient was functioning at the sedentary physical demand level and a work conditioning program was recommended. On 06/09/05, Dr. Westfield recommended a repeat EMG/NCV study, continued splinting, and possible surgery. On 06/17/05, Dr. Rodriguez recommended an orthopedic evaluation. On 07/08/05, Dr. Stephenson felt the patient was not at Maximum Medical Improvement (MMI) and he recommended an orthopedic evaluation with possible steroid injections or a return to work program. On 09/22/05, Dr. Stephenson recommended an evaluation with a hand surgeon for possible surgery. On 10/06/05, Dr. Katz performed a wrist injection and recommended a repeat EMG/NCV study. Dr. Clemence wrote a letter of medical necessity for a portable infrared heating unit, a therapeutic knee support, shoe orthotics, and a topical gel on 10/12/05. An EMG/NCV study interpreted by Dr. Truett on 10/25/05 was unremarkable.

Disputed Services:

Massage therapy, electrical stimulation unattended, therapeutic exercises, manual therapy techniques, office visits, electrical stimulation, and a Functional Capacity Evaluation (FCE) from 03/29/05 through 07/11/05

Decision:

I partially agree with the requestor. The massage therapy, electrical stimulation unattended, therapeutic exercises, manual therapy techniques, office visits, and electrical stimulation from 03/29/05 through 04/21/05 were reasonable and necessary as related to the original injury. The massage therapy, electrical stimulation unattended, therapeutic exercises, manual therapy techniques, office visits,

and electrical stimulation from 04/22/05 through 07/11/05, including an FCE on 05/16/05, were not reasonable or necessary as related to the original injury.

Rationale/Basis for Decision:

According to the medical records reviewed, the patient injured her right wrist on _____. She was initially examined on 02/24/05 by her treating physician. She was referred for an MRI of the right wrist on 02/28/05, which revealed a partial tear of the scapholunate ligament. The patient began passive and active treatment for the right wrist. According to the Official Disability Guidelines, 2005, treatment for a wrist sprain is eight weeks. In addition, Wheelless' Textbook of Orthopaedics, 1997, states the patient should also wear a wrist splint and be referred to an orthopedic surgeon if conservative treatment does not decrease the symptoms. Using the above stated treatment guidelines, beginning on 02/24/05, eight weeks of treatment would end on 04/25/05. It should also be noted the patient's reexamined findings from 04/25/05 were virtually identical to her initial examination on 02/24/05. At that point, the patient's symptoms had plateaued and only casting of the wrist or a referral for surgery would be medically necessary after 04/22/05. Further office visits, passive treatment, and active treatment for the ligament tear after 04/22/05 was not medically necessary. In short, the massage therapy, electrical stimulation unattended, therapeutic exercises, manual therapy techniques, office visits, and electrical stimulation from 03/29/05 to 04/21/05 were medically necessary to treat the patient and those above mentioned treatments, including an FCE on 05/16/05, were not medically necessary to treat this patient.

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

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division 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 01/31/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel