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: Southeast Health Services P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-0691-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Box 42	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
POSITION SUMMARY: Per the table of disputed services "Please see the attached letter of medical necessity for the treatment provided to this patient"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: No position summary submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-03-04 to 02-24-05	99211, 99212, 99214, 97032, 97110, 97016, 97140, A9150, E0745, 64550 and 99080-73	☐ Yes ☒ 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		02-06-06 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 Austin, Texas 78735
Phone: 512-288-3300 FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED FEBRUARY 3, 2006

TDI-WC Case Number:	___
MDR Tracking Number:	M5-06-0691-01
Name of Patient:	___
Name of URA/Payer:	Southeast Health Services
Name of Provider: (ER, Hospital, or Other Facility)	Southeast Health Services
Name of Physician: (Treating or Requesting)	Mark McMahon, DC

January 27, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

DOCUMENTS REVIEWED
Medical Dispute Resolution Request/Response
Letter of Medical Necessity-Bryan Weddle, DC
IME Report-Charles Graham, MD
MRI of Right Knee-Nicholas Iwasko, MD
X-ray reports-Darrell Hobson, DC

Operative reports-Hugo Walker, MD
Designated Doctor Evaluation-Roger Moczygemba, MD
Orthopedic notes and reports-John McConnell, MD
Medical reports-Charles Willis, MD
Chiropractic reports and notes-Bryan Weddle, DC, Mark McMahon, DC

CLINICAL HISTORY

Available information suggests that this patient reports experiencing an occupational injury on ___ when she slipped and fell on a wet floor landing on her knees. She was treated initially by her chiropractor, Dr. Weddle, and was found with bilateral sprain/strain and contusion. She underwent multiple sessions of physical therapy. She was seen for medical evaluation by a Dr. Willis on 10/19/04 and was found unresponsive to conservative care. MRI of the knee was ordered and the patient was placed on analgesic and anti-inflammatory medication. An MRI is obtained on 10/20/04 suggesting a grade 4 tear of the medial meniscus with grade 1 myxoid degeneration of the lateral surface. Chondromalacia changes and osteophyte formation suggests tricompartmental degenerative change of long duration. The patient is obese and has previous history of knee problems. The patient is referred for orthopedic assessment with a Dr. McConnell with recommendations for arthroscopic evaluation and possible meniscus repair. The patient appears to continue with chiropractic treatment and passive modalities with limited improvement. Chiropractor also appears to begin active therapeutic exercise at 3-5 units per day from 12/04/04 to 01/12/05. No FCE or other assessment of functional capacity appears to be performed. The patient is scheduled for follow-up orthopedic assessment by orthopedist on 01/31/05 but this appointment is not kept. A notice of non-compliance was submitted by Dr. McConnell. Chiropractor also appears to prescribe a vasopneumonic device with a Matrix system stimulator apparently for a non-invasive nerve block application. Designated doctor evaluations were made on 03/18/05 and 08/19/05 and suggest that the patient has achieved MMI with a 2% WP impairment rating. Inspection of the right knee is normal and no instability or neurological deficit is noted.

REQUESTED SERVICE(S)

Determine medical necessity for office visits (99211, 99212, 99214–OV), electric stimulation (97032), therapeutic exercises (97110), vasopneumatic devices (97016), DME (E0745), manual therapy (97140), non-prescription drugs (A9150), application of neurostimulator (64550) and DWC report (99080-73) for period in dispute 12/03/04 through 02/24/05,.

DECISION

All services denied.

RATIONALE/BASIS FOR DECISION

Early intervention for injuries related to sprain / strain and contusions of the injured extremities does appear reasonable and appropriate for initial 4-6 weeks following injury. However, all services in dispute from 12/03/04 through 02/24/05 exceed reasonable and customary applications for ongoing degenerative conditions and operative orthopedic conditions. With noted meniscal tear and potential interarticular loose bodies, manual therapy and manipulation would be contraindicated. Continuation of active therapeutic exercise could not be considered medically appropriate without orthopedic recommendation and appropriate evaluation of functional deficits. In addition, pre-existing conditions, obesity and non-compliance with orthopedic recommendations make this patient a poor candidate for ongoing therapeutic interventions of this nature.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. NIH/Arthritis Foundation, "*Guidelines for managing degenerative knee disorders*" U.S. National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20894, November 2005.

3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "*Managing musculoskeletal complaints with rehabilitation therapy*" Journal of Family Practice, Dec, 2002.
5. AAOS Public Education, "*Guidelines for Surgical Management of the Degenerative Knee*" Journal of the American Academy of Orthopaedic Surgeons, Oct. 2004.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.

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.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Marc Salvato