



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: Puig Rehabilitation, L.P. 500 East Dove Ave McAllen, TX 78504	MDR Tracking No.: M5-06-0797-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TX Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Texas Mutual requests that the request for dispute resolution filed be conducted under the provisions of the APA set out above."

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)
3-30-05 – 5-26-05	CPT code 97110-GP (\$33.56 X 40 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,342.40
3-30-05 – 5-26-05	CPT codes 97035-GP, 97140, G0283-GP 97140-GP, 97012-GP, 95851-GP-59	<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 \$1,342.40.

In a letter dated 2-6-06 the requestor withdrew CPT code 97010 for all dates of service.

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 Division has determined that the requestor is entitled to a refund of the IRO fee (\$650.00). The requestor is entitled to additional reimbursement in the amount of \$1,342.40. 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

2-21-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0797-01
NAME OF REQUESTOR: Bertha Puig
NAME OF PROVIDER: Kip Owens, M.D.
REVIEWED BY: Board Certified in Orthopedic Surgery
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 02/08/06

Dear Ms. Puig:

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 Board Certified in the area of Orthopedic Surgery 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 evaluation with Alberto H. Gutierrez, Jr., M.D. dated 11/03/04
An MRI of the right shoulder interpreted by Andrew Bauer, M.D. dated 11/19/04

Evaluations with Kip Owen, M.D. dated 12/09/04, 12/27/04, 12/31/04, 01/05/05, 01/17/05, 01/24/05, 02/02/05, 02/08/05,

03/09/05, 03/17/05, 04/11/05, 04/26/05, 05/26/05, 11/14/05, and 12/05/05

An operative report from Dr. Owen dated 12/29/04

Evaluations with Kevin Abers, P.T. dated 01/25/05 and 03/17/05

Physical therapy with Adrian David Flores, L.P.T.A. and Mr. Abers dated 03/17/05, 03/21/05, 03/23/05, 03/28/05, 03/30/05, 04/01/05, 04/04/05, 04/06/05, 04/08/05, 04/11/05, 04/13/05, 04/14/05, 04/18/05, 04/20/05, 04/25/05, 04/26/05, 05/02/05, 05/04/05, 05/09/05, 05/11/05, 05/16/05, 05/18/05, 05/23/05, and 05/16/05

A letter from Elizabeth Alvarado-Gaona, Office Manager at Puig Rehabilitation, dated 10/26/05

A letter from Richard X. Ball, Claims Operator at Texas Mutual Insurance Company, dated 01/11/06

A letter from LaTreace E. Giles, R.N., Senior Medical Dispute Analyst from Texas Mutual Insurance Company, dated 01/25/06

Clinical History Summarized:

An MRI of the right shoulder interpreted by Dr. Bauer on 11/19/04 revealed a rotator cuff tear and small to moderate joint effusion. On 12/09/04, Dr. Owen recommended physical therapy, Darvocet, and surgery. On 12/29/04, Dr. Owen performed a right rotator cuff repair and arthroscopic subacromial decompression/acromioplasty. Physical therapy was performed with Mr. Abers and Mr. Flores from 03/17/05 through 05/16/05 for a total of 24 sessions. On 04/11/05, Dr. Owen recommended an MRI of the cervical spine. On 05/26/05, Dr. Owen felt the patient was at Maximum Medical Improvement (MMI) and recommended an impairment rating evaluation. On 10/26/05, Ms. Alvarado-Gaona wrote a letter to the appeals department of Texas Mutual Insurance Company requesting payment for the dates of 03/17/05 through 05/26/05. On 11/14/05, Dr. Owen recommended resuming rehabilitation, a possible shoulder injection, and a possible MRI. A shoulder injection was performed by Dr. Owen on 12/05/05. Mr. Ball wrote a letter on 01/11/06 stating Puig Rehabilitation had requested a Medical Dispute Resolution. On 01/25/06, Ms. Giles wrote a letter in response to the dispute.

Disputed Services:

97110-GP-therapeutic exercises, 97035-GP-ultrasound, 97140-manual therapy technique, GO283-GP-electrical stimulation, 97140-GP-manual therapy technique, 97012-GP-mechanical traction, and 95851-GP-59-range of motion measurements from 03/30/05 through 05/26/05

Decision:

I partially agree with the requestor. The 97110-GP-therapeutic exercises were reasonable and necessary from 03/30/05 through 05/26/05. However, the 97035-GP-ultrasound, 97140-manual therapy technique, GO283-GP-electrical stimulation, 97140-GP-manual therapy technique, 97012-GP-mechanical traction, and 95851-GP-59-range of motion measurements from 03/30/05 through 05/26/05 were neither reasonable nor necessary.

Rationale/Basis for Decision:

The patient continued to complain of pain between the time of 03/30/05 and 05/26/05. During that timeframe, the patient would have benefited from therapeutic exercise (97110-GP) alone. Ultrasound (97035-GP), manual therapy technique (97140 and 97140-GP), electrical stimulation (GO283-GP), mechanical traction (97012-GP), and range of motion measurements (95851-GP-59) would have been neither reasonable nor necessary. Criteria used included Rockwood, The Shoulder and Campbell, Operative Orthopedics.

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 02/08/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel