



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: Jairo A. Puentes, M.D. 3434 Saratoga Blvd Corpus Christi, Texas 78415	MDR Tracking No.: M5-06-0869-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

PRINCIPLE DOCUMENTATION: DWC-60 dispute package
 POSITION SUMMARY: "The insurance carrier has denied these treatments. I am requesting payment for these services, since they were medically necessary to help Mr. _____ to return to gainful employment as per labor code. Mr. _____ is back to work on regular duty".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

PRINCIPLE DOCUMENTATION: Response to DWC-60
 POSITION SUMMARY: "Texas Mutual requests that the request for dispute resolution filed by Jairo A. Puentes, be conducted under the provisions of the APA set out above".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-24-05 to 06-22-05	97018, 97530 and 97035	<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 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:

03-15-06

Authorized Signature

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT:
IRO CASE NUMBER: M5-06-0869-01
NAME OF REQUESTOR: Jairo A. Puentes, M.D.
NAME OF PROVIDER: Jairo A. Puentes, M.D.
REVIEWED BY: Board Certified in Orthopedic Surgery
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 03/08/06 (REVISED 03/14/06)

Dear Dr. Puentes:

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:

Evaluations with Jairo Puentes, M.D. dated 02/15/05, 03/11/05, 04/13/05, 05/06/05, 05/27/05, 06/20/05, and 11/07/05
Physical therapy visits with Dr. Puentes dated 03/14/05, 03/21/05, 03/22/05, 03/23/05, 03/24/05, 03/28/05, 03/29/05, 03/30/05, 03/31/05, 04/01/05, 04/04/05, 04/05/05, 04/06/05, 04/07/05, 04/08/05, 04/11/05, 04/12/05, 04/13/05, 04/14/05,

04/15/05, 04/18/05, 04/19/05, 04/21/05, 04/25/05, 04/26/05, 05/02/05, 05/03/05, 05/04/05, 05/05/05, 05/06/05, 05/09/05,

05/10/05, 05/11/05, 05/12/05, 05/13/05, 05/16/05, 05/17/05, 05/18/05, 05/19/05, 05/20/05, 05/23/05, 05/24/05, 05/25/05, 05/26/05, 05/27/05, 05/31/05, 06/01/05, 06/02/05, 06/03/05, 06/06/05, 06/07/05, 06/08/05, 06/09/05, 06/10/05, 06/13/05, 06/14/05, 06/15/05, 06/20/05, and 06/22/05

A letter from LaTreace E. Giles, R.N. at Texas Mutual Insurance Company dated 02/15/06

Clinical History Summarized:

Dr. Puentes performed a laceration repair and prescribed Lortab, Rocephin, and Cipro on 02/15/05. On 03/11/05, Dr. Puentes recommended physical therapy five days a week for two weeks. Physical therapy was performed with Dr. Puentes from 03/14/05 through 06/22/05 for a total of 59 sessions. On 06/20/05, Dr. Puentes recommended continued physical therapy three times a week for two weeks. On 11/07/05, Dr Puentes felt the patient was at Maximum Medical Improvement (MMI) with an 8% whole person impairment rating. On 02/15/06, Ms. Giles, from Texas Mutual, wrote a letter regarding reimbursement for treatment. A request for medical dispute resolution had been filed. Ms. Giles noted the patient's pain level had dropped by 04/21/05 and the amount and duration of passive therapy was not supported.

Disputed Services:

Paraffin bathes, ultrasound, and therapeutic activities from 03/24/05 through 06/22/05

Decision:

I disagree with the requestor. I do not feel the therapeutic activities (97530) from 03/30/05 through 06/22/05 were reasonable or necessary. The paraffin bathes (97018) and ultrasound (97035) from 03/24/05 through 06/22/05 were neither reasonable nor necessary.

Rationale/Basis for Decision:

This patient sustained an injury on ___ that included multiple finger lacerations with tendon involvement. This was repaired on the date of injury. The patient sustained those lacerations, which appeared to be quite severe and as expected, the patient developed subsequent stiffness. A reasonable amount of therapeutic activities should be expected for this and this could reach eight to ten weeks of therapy, which in my opinion would have finished out on 03/29/05. Therefore, in my opinion, from 03/30/05 through 06/22/05, further supervised therapy in the form of therapeutic activities would not be necessary. The patient by then should have had nearly two full months of supervised therapy and there was no evidence additional therapeutic activities at this point would improve the patient's outcome. In addition, there was no peer review literature that proved the effectiveness of paraffin baths and ultrasound. The literature simply does not support their use regularly as a treatment for stiffness. Thus, in my opinion, the paraffin bath and ultrasound would not have been reasonable or necessary.

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 03/14/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel