



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:
Health & Medical Practice Associates
324 Nth 23rd Street, Suite 201
Beaumont, Texas 77707

MDR Tracking No.: M5-06-0882-01 (current MDR#)
M5-06-0426-01 (former MDR#)

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Box 45

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 "medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: None 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)
05-05-05 to 05-20-05	97035, 97140 and 97124	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$389.67
05-05-05 to 07-18-05	97530	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$210.90
05-05-05 to 08-05-05	97032	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
05-24-05 to 08-05-05	97035, 97140 and 97124	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
07-22-05 to 08-05-05	97530	<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.

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 \$600.57. 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:

02-01-06

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.



CompPartners Final Report ACCREDITED EXTERNAL REVIEW

CompPartners Peer Review Network
Physician Review Recommendation
Prepared for TDI/DWC

Claimant Name: _____
Texas IRO # : _____
MDR #: M5-06-0882-01
Social Security #: _____
Treating Provider: Patrick McMeans, MD
Review: Chart
State: TX
Amended Date: 1/26/06

Review Data:

- Notification of IRO Assignment dated 10/7/05, 1 page.
- Receipt of Request dated 11/10/05, 1 page.
- Medical Dispute Resolution Request dated 10/25/05, 1 page.
- List of Treating Providers (date unspecified), 1 page.
- Table of Disputed Services dated 8/5/05, 7/25/05, 7/22/05, 7/18/05, 7/8/05, 7/6/05, 7/5/05, 6/30/05, 6/29/05, 6/24/05, 6/22/05, 6/20/05, 6/16/05, 6/15/05, 6/13/05, 6/8/05, 6/6/05, 6/3/05, 6/2/05, 5/25/05, 5/24/05, 5/20/05 5/19/05, 5/17/05, 5/16/05, 5/11/05, 5/5/05, 4 pages.
- Explanation of Benefits dated 7/25/05, 7/22/05, 7/18/05, 7/8/05, 7/6/05, 7/5/05, 6/30/05, 6/29/05, 6/24/05, 6/22/05, 6/20/05, 6/16/05, 6/15/05, 6/13/05, 6/8/05, 6/6/05, 6/3/05, 6/2/05, 5/25/05, 5/24/05, 5/20/05 5/19/05, 5/17/05, 5/16/05, 5/11/05, 5/5/05, 35 pages.
- Dispute Letter dated 11/17/05, 1 page
- Article on Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries (date unspecified), 39 pages.
- Progress Notes dated 7/28/05, 1 page.
- Sensory Nerve Conduction dated 7/28/05, 5/17/05, 12 pages.
- Diagnostic X-ray and Physiotherapy Prescription dated 8/5/05, 7/28/05, 7/25/05, 7/22/05, 5/17/05, 5/16/05, 6 pages.
- Motor Nerve Conduction Study dated 7/25/05, 7/22/05, 5/16/05, 3 pages.
- Emergency Physician Record dated 4/27/05, 2 pages.
- Initial Report dated 5/2/05, 4 pages.
- Daily Notes dated 8/5/05, 8/1/05, 7/29/05, 7/28/05 7/25/05, 7/22/05, 7/18/05, 7/15/05, 7/8/05, 7/6/05, 7/5/05, 6/30/05, 6/29/05, 6/24/05, 6/22/05, 6/20/05, 6/16/05, 6/15/05, 6/13/05, 6/8/05, 6/6/05, 6/3/05, 6/2/05, 5/31/05, 5/25/05, 5/24/05, 5/20/05, 5/19/05, 5/17/05, 5/16/05, 5/11/05, 5/9/05, 5/5/05, 5/3/05, 5/2/05, 58 pages.
- Initial Medical Consultation dated 5/2/05, 2 pages.
- Medical Progress Notes dated 7/14/05, 6/24/05, 6/16/05, 6/2/05, 5/16/05, 11 pages.
- Physiotherapeutic Notes dated 8/9/05, 8/5/05, 8/1/05, 7/29/05, 7/28/05, 7/25/05, 7/22/05, 7/18/05, 7/15/05, 7/8/05, 7/6/05, 7/5/05, 6/30/05, 6/29/05, 6/24/05, 6/22/05, 6/20/05, 6/15/05, 6/13/05, 6/8/05, 6/6/05, 6/3/05, 6/2/05, 5/25/05, 5/24/05, 5/20/05, 5/19/05, 5/17/05, 5/16/05, 5/11/05, 5/9/05, 5/5/05, 10 pages.
- Cervical and Thoracic Spine X-ray dated 6/2/05, 1 page.
- Table of Contents (date unspecified), 2 pages.
- References, 1 page.
- Denial Letter dated 11/23/05, 6 pages.
- Article on TriCenturion Investigations of Physical Medicine Services (date unspecified), 2 pages.
- Medical Fee Guidelines (date unspecified), 1 page.
- Article on Physical Medicine and Rehabilitation (date unspecified), 7 pages.
- Office Visits dated 6/22/05, 6/20/05, 6/16/05, 6/13/05, 6/8/05, 6/6/05, 6/3/05, 6/2/05, 5/26/05, 5/24/05, 5/20/05, 5/19/05, 5/17/05, 5/16/05, 5/11/05, 5/9/05, 5/5/05, 1 page.

- Fax Cover Sheet dated 5/17/05, 1 page.
- Workers Compensation Prescription Form dated 4/21/05, 1 page.
- Prescription dated 5/16/05, 2 pages.
- Texas Workers' Compensation Work Status Report dated 6/16/05, 6/2/05, 5/16/05, 3 pages.
- Consultation dated 7/14/05, 6/2/05, 10 pages.
- Functional Capacity Evaluation dated 7/15/05, 5/31/05, 29 pages.
- Referral Form dated 6/17/05, 1 page.
- Cervical and Thoracic Spine, Right Shoulder MRI dated 6/28/05, 6 pages.
- Health Insurance Claim Form dated 9/8/05, 9/6/05, 9/1/05, 8/30/05, 6/29/05, 6/27/05, 30 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied ultrasound (97035), manual therapy techniques (97140), electrical stimulation (97032), massage (97124), and therapeutic activities (97530) from 5/5/05 to 8/5/05.

Determination: PARTIAL – UPHOLD – electrical stimulation (97032) from 5/5/05 to 8/5/05, ultrasound (97035), manual therapy techniques (97140), massage (97124) from 5/24/05 to 8/5/05, and therapeutic activities (97530) from 7/22/05 through 8/5/05.

PARTIAL – REVERSED - ultrasound (97035), manual therapy techniques (97140), and massage (97124) from 5/5/05 through 5/20/05; therapeutic activities (97530) from 5/5/05 through 7/18/05.

Rationale:

Patient's age:

Gender:

Date of Injury: ____

Mechanism of Injury: Struck on the right shoulder/chest by full carton of milk thrown at a high rate of speed, causing her to stumble backward and fall into a chair.

Diagnoses: Right shoulder internal derangement.
Cervical strain.
Thoracic strain.

The claimant is a 20 year-old female corrections officer who sustained a right shoulder, neck, and thoracic injury on ____ when she was struck by a milk carton and fell backward. She was seen in the emergency department with negative X-rays and treated conservatively with medications and physical therapy. Therapy modalities included manual therapy, ultrasound, joint mobilization, therapeutic exercises, electrical stimulation, and massage. She treated for twenty-seven visits from 05/05/05 to 08/05/05. There was notation of improved motion and strength following treatment. After review of the records, the ultrasound between 05/05/2005 and 05/20/2005 was reasonable and necessary for this claimant. According to the guidelines, treatment for up to one-month after injury is reasonable and appropriate and this would be reasonable and appropriate to reduce pain. Similarly, the manual therapy for one month, until 05/21/2005, was reasonable and necessary. The electrical stimulation (97032) was not medically necessary as it has not been proven to be effective. The massage (97124) through 05/20/2005, again, is reasonable and necessary. Therapeutic activities are reasonable for the first three months from 05/05/2005 through 07/18/2005. Each of these would be reasonable for a period of time, as stated to reduce pain and allow transition to therapeutic exercise, followed by a home program. Modalities and supervised therapy beyond the dates specified would be merely palliative and would not lead to a more rapid recovery or better overall improvement of the condition. Additional treatment beyond those guidelines was not medically necessary and not justified by the information that was presented for review.

Criteria/Guidelines utilized: TDI/DWC rules and regulations.

ACOEM Guidelines, 2nd Edition, Chapter 8 and 9.

Clinical Orthopaedic Rehabilitation, 2nd Edition, by S. Brent Brotzman & Kevin S. Wilk, Chapter 3, page 152.

Physician Reviewers Specialty: Orthopedics

Physician Reviewers Qualifications: Texas licensed MD, and is also currently listed on the TDI/DWC ADL list.

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist 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 the decision before the referral to CompPartners, Inc.

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.