



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: South Coast Spine and Rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M5-06-1008-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dean G. Pappas & Associates Rep Box # 25	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: "The health care provider is the requestor in this Medical Dispute Resolution by an Independent Review Organization and therefore 133.308(c)(1) requirements have been met".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No Respondent response received

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-31-05 to 11-28-05	97124 (2 units @ \$53.26 X 13 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$692.38
	97110 (4 units @ \$134.24 X 13 DOS)		\$1,745.12
	97032 (1 unit @ \$19.00 X 13 DOS)		\$247.00
TOTAL			\$2,684.50

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 **prevailed** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202

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 \$2,684.50. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$460.00). 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:

05-12-06

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
INTERNAL REVIEW

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

Claimant Name: _____
Texas IRO # : _____
MDR #: M5-06-1008-01
Social Security #: _____
Treating Provider: E. Ray Strong, DC
Review: Chart
State: TX
Date Completed: 5/5/06

Review Data:

- Notification of IRO Assignment dated 3/1/06, 1 page.
- Receipt of Request dated 3/1/06, 1 page.
- Medical Dispute Resolution Request/Response dated 1/30/06, 1 page.
- List of Treating Providers (date unspecified), 1 page.
- List of Disputed Services dated 11/28/05, 11/23/05, 11/22/05, 11/21/05, 11/17/05, 11/16/05, 11/14/05, 11/10/05, 11/9/05, 11/7/05, 11/3/05, 11/2/05, 10/31/05, 2 pages.
- Billing Statement dated 12/15/05, 12/8/05, 12/7/05, 11/30/05, 4 pages.
- Final Request for "Medical Dispute Resolution" Per TWCC dated 3/6/06, 15 pages.
- Table of Contents (date unspecified), 1 page.
- Initial Evaluation dated 6/27/05, 3 pages.
- Consultation dated 12/21/05, 10/31/05, 9/12/05, 7 pages.
- Re-evaluation dated 12/8/05, 10/5/05, 9/19/05, 24 pages.
- Left Knee MRI dated 7/6/05, 1 page.
- Initial Functional Capacity Evaluation dated 10/31/05, 11 pages.
- Second Functional Capacity Evaluation dated 12/7/05, 11 pages.
- Office Visit dated 11/28/05, 11/23/05, 11/22/05, 11/21/05, 11/17/05, 11/16/05, 11/14/05, 11/10/05, 11/9/05, 11/7/05, 11/3/05, 11/2/05, 10/31/05, 85 pages.
- Texas Workers' Compensation Work Status Report dated 12/8/05, 10/31/05, 9/19/05, 9/7/05, 8/19/05, 6/27/05, 6 pages.
- Employee's Request to Change Treating Doctors Authorization dated 6/27/05, 1 page.
- Orthopedic Evaluation dated 7/5/05, 3 pages.
- Office Notes dated 8/2/05, 1 page.
- Referral dated 8/19/05, 1 page.
- Prescription dated 9/19/05, 1 page.
- Operative Report dated 9/8/05, 2 pages.

Reason for Assignment by TDI/DWC: Determine the appropriateness of the previously denied request for:

1. Therapeutic exercises (97110).
2. Electrical stimulation (97032).
3. Massage therapy (97124).

Dates of service: 10-31-05 through 11-28-05.

Determination: REVERSED -

1. Therapeutic exercises (97110).
2. Electrical stimulation (97032).
3. Massage therapy (97124).

Dates of service: 10-31-05 through 11-28-05.

Rationale:

Patient's age: -

Gender:

Date of Injury: ____

Mechanism of Injury: Fell to the cement ground on both knees.

Diagnoses: Tear of meniscus, left knee; sprain/strain of knee, ankle sprain/strain; and post operative left knee on 9/8/05.

The patient had a MRI of the left knee on 5/24/05, which revealed a tear of the lateral meniscus involving the articular surface of the femur. She was evaluated and treated by Jorge Tijmes, MD, an orthopedic surgeon, and recommended for arthroscopic left knee surgery. She was referred to Oliver Achleitner, MD, who did the arthroscopic surgery on 9/8/05, with partial lateral meniscectomy. She was released to start post operative rehabilitation with her chiropractor, Ray E Strong, on 9/18/05, with a prescription for range of motion, pain relief and a strengthening program. She was reported to be off her crutches as of 10/3/05. She had improved range of motion on 10/5/05, at 110 degrees flexion from 98 degrees flexion on 9/19/05. Treatments continued and ranges of motion progressively increased with each visit by 1-2 degrees, to 145 degrees flexion on 11/28/05, and 0 degrees extension. Pain scales progressively reduced to 2/10 pain scale on 11/28/05. The patient also had documentation which reflected appropriate and progressive amounts of weight lifting improvements through 11/28/05. McMurray's sign remained present post surgically on each visit, in internal and external rotation, without changes. As of the daily notes, on 11/28/06, she was able to work full time with restrictions. The current request is to determine the medical necessity for these charges for dates of service of 10/31/05 through 11/28/05. The medical necessity was found. This determination is within the Texas Department of Insurance rules and regulations, as well as the Reference to the Official Disability Guidelines, 2006, 11th edition, page 200, for post surgical knee, which allows for up to 24 rehabilitation/physical therapy visits over 16 weeks. This patient would be within that timeframe for medical necessity of the services listed below, and did have appropriate response to treatment and with appropriate documentation from the provider to support these services. 1) Certification for Therapeutic exercises code 97110, on 11/22/05, 11/23/05, 11/28/05, 10/31/05, 11/2/05, 11/3/05, 11/7/05, 11/9/05, 11/10/05, 11/14/05, 11/16/05, 11/17/05, 11/21/05, 2) Certification for Electrical stimulation code 97032 on 11/21/05, 11/22/05, 11/23/05, 11/28/05, 10/31/05, 11/2/05, 11/3/05, 11/7/05, 11/9/05, 11/10/05, , 11/14/05, 11/16/05, 11/17/05, 3) Certification for Massage therapy code 97124 on 11/22/05, 11/23/05, 11/28/05, 10/31/05, 11/2/05, 11/3/05, 11/7/05, 11/9/05, 11/10/05, 11/14/05, 11/16/05, 11/17/05, 11/21/05,

Criteria/Guidelines utilized: Texas Department of Insurance /TWCC-Rules and Regulations. Official Disability Guidelines, 2006, 11th edition, page 200 for post surgical knee.

Physician Reviewers Specialty: Chiropractor

Physician Reviewers Qualifications: Texas Licensed DC, BSRT, FIAMA Chiropractor 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.