



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	
Requestors Name and Address: Health and Medical Practice Associates 324 N. 23 rd St. Ste. 201 Beaumont, TX 77707	MDR Tracking No.: M5-06-1249-01
	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

Documents include the DWC-60 package. Position Summary states, "Medically necessary."

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)
4-28-05 – 9-15-05	CPT codes 97124, 97032, 97035, 99213-25, 97140, 95900-59, 95904-59	<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 not prevail on the disputed medical necessity issues.

In a letter dated 6-23-06 CPT code 97530 on 9-15-05 has been withdrawn by the requestor and will not be a part of this review.

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

Medical Dispute Officer

Typed Name

6-26-06

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.

MATUTECH, INC.

**PO Box 310069
New Braunfels, TX 78131
Phone: 800-929-9078
Fax: 800-570-9544**

May 6, 2006

Texas Department of Insurance
Division of Workers' Compensation
Fax: (512) 804-4001

Re: Medical Dispute Resolution
MDR#: M5-06-1249-01
DWC#: _____
Injured Employee: _____
DOI: _____
IRO Certificate No.: IRO5317

Dear Ms.

Matutech, Inc. has performed an Independent review of the medical records of the above-named case to determine medical necessity. In performing this review, Matutech reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

Matutech certifies that the reviewing healthcare professional 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.

Information and medical records pertinent to this medical dispute were obtained from Health & Medical Practice Association. The Independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in physical medicine and rehabilitation, and is currently on the DWC Approved Doctor list.

Sincerely,

John Kasperbauer
Matutech, Inc.

REVIEWER'S REPORT

Information provided for review:

Request for Independent Review

Information provided by Health & Medical Practice Association:

Office notes (04/26/05 – 09/01/05)

Therapy notes (04/28/05 – 08/15/05)

FCE (08/22/05)

Electrodiagnostic studies (08/18/05 – 08/19/05)

Clinical History:

This is a 46-year-old male who sustained injuries to the left side of his neck; and left shoulder, hand and wrist while attempting to remove a sheet of felt paper that was tacked down. The hook glided across the paper and cut his left wrist. Patrick McMeans, M.D., evaluated the patient for complaints of neck pain and stiffness on the left side, left shoulder pain, left wrist pain and burning, left forearm pain, and some numbness and swelling of the left hand. Maximal foraminal compression test and cervical compression test were positive on the left. X-rays of the cervical spine revealed a moderately decreased lordotic curve, mild scoliosis apexed at C5, narrowed disc space visualized at C5-T1, anterior inferior vertebral body osteophyte formation, and foraminal encroachment at C5-T1. X-rays of the left wrist revealed a complete fracture of the ulnar styloid. Dr. McMeans diagnosed cervical, left forearm, and left wrist sprain/strain; cervical radiculitis; deep and superficial muscle spasm; left wrist ulnar styloid fracture; and anterior/inferior forearm laceration. He recommended therapy three times a week for six weeks, a functional capacity evaluation (FCE), and a computerized range of motion (ROM) study. Lortab, baclofen, and Sonata were prescribed. From April 28, 2005, through August 19, 2005, the patient attended 13 sessions of physical therapy (PT) consisting of electrical stimulation, ultrasound, therapeutic procedures, and mechanical traction (97012). Dr. McMeans recommended additional therapy. In August, a motor nerve conduction velocity (NCV) study revealed axillary and median nerve involvement. A sensory nerve study revealed very severe hypesthesia in the trigeminal, C2, C6, C7, and C8. In an FCE, the patient qualified at a medium to heavy physical demand level (PDL) whereas his work required a light PDL. Dr. McMeans recommended continuation of a supervised active therapy to help restore normal ROM, function, endurance and strength and flexibility. From August 25, 2005, through September 15, 2005, the patient attended 8 sessions of PT consisting of ultrasound, electrical stimulation, therapeutic procedure, massage therapy, and therapeutic activities.

Disputed Services:

Massage therapy (97124), electrical stimulation (97032), ultrasound (97035), office visits (99213-25), manual therapy technique (97140), nerve conduction no F wave (95900-59), and sensory testing each nerve (95904-59).

Dates of service: 04/28/05 through 09/15/05.

Explanation of Findings:

Work related injury indicated to be wrist area laceration with emergency repair. Due to persisting pain, an ulnar styloid fracture (age not determined) on x-rays. The primary work injury, laceration, would require only 2-3 weeks for healing for which no therapy services would be medically reasonable and necessary. The ulnar styloid fracture would not require any of the therapy in question including massage therapy, electrical stimulation, ultrasound, office visits, manual therapy techniques. In the absence of specific clinical findings nerve conduction and sensory testing, are not medically reasonable and necessary for the described work injury.

Conclusion/Decision To Uphold, Overturn or Partially Uphold/Overturn denial:

Based on the review of submitted medical documentation, it is my recommendation that the original denial be upheld.

Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:

National standardized guidelines including American College of Occupational & Environmental Medicine, Medical Disability Advisor and the Cochrane Collaboration

The physician providing this review is a medical doctor. The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Electrodiagnostic Medicine. The reviewer is a member of American Academy of Physical Medicine & Rehabilitation. The reviewer has been in active practice for 35 years.

Matutech is forwarding this decision by mail and in the case of time sensitive matters by facsimile to the Texas Department of Insurance, Division of Workers Compensation.

Matutech retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by Matutech clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the Utilization Review Accreditation Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by Matutech represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to Matutech for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Matutech assumes no liability for the opinions of its contracted physicians and/or clinician advisors the health plan, organization or other party authorizing this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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.