



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: Injury 1 Treatment Center 5445 La Sierra Drive # 204 Dallas, Texas 75231	MDR Tracking No.: M5-06-1828-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Wausau Underwriters Insurance Rep Box # 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Wausau Insurance has established an unfair and unreasonable time frame in paying for the services that were authorized and rendered to Mr. _____. Your help in resolving this case is appreciated."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: Per the Table of Disputed Services "Denied per Peer Review."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-23-05, 07-08-05, 07-11-05, 07-15-05, 07-20-05 and 07-27-05	97010 (see note below regarding reimbursement)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$0.00
06-23-05, 07-08-05, 07-11-05, 07-15-05, 07-20-05 & 07-27-05	97032 (1 unit @ \$19.00 X 6 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$114.00

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-23-05 to 07-27-05	97035 (1 unit @ \$14.63 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$131.67
06-23-05 to 07-27-05	97110 (1 unit @ \$33.56 X 4 units X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,208.16
	Note: Per Rule 134.202 CPT code 97010 is a bundled service code and considered an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code. Therefore, additional payment is not recommended.		
TOTAL DUE			\$1,453.83

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202(c)(1)
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 \$1,453.83. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the Respondent 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.

Order by:

10-02-06

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.

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71
Phone: 512-288-3300

Austin, Texas 78735
FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-1828-01
Name of Patient:	
Name of URA/Payer:	Injury One Treatment Center
Name of Provider: (ER, Hospital, or Other Facility)	Injury One Treatment Center
Name of Physician: (Treating or Requesting)	Shawn Fike, DC

August 16, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Division of Workers' Compensation

DOCUMENTS REVIEWED

Available documentation received and included for review consists of initial and subsequent reports and treatment records from Dr. Fike (DC), PT records Injury 1 Treatment Center, including FCE's and Psychotherapy notes; treatment notes, Dr. David Schickner (MD). Chronic pain management intake and treatment notes (Healthsouth), orthopedic opinion consults / follow-ups Dr. Iabraian (MD), and Dr. William Blair (MD), Peer review report Dr. Davis Bowerman (DC). Designated doctor report Dr. Howard Douglas (MD).

CLINICAL HISTORY

Mr. ____, a 41-year-old male, sustained an on-the-job injury to his left shoulder on _____. He had numerous rounds of physical therapy, MRI's were positive for repair of the supraspinatus tendon. Cortisone steroid injections were unsuccessful, he finally underwent left shoulder surgery on 10/13/03, subsequently had wound infection postoperatively, and then underwent a four-month rehab program. He was placed at MMI at his own insistence, denying a recommended pain management program. Patient suffered a flare-up on 2/11/05 and was seen by Dr. Yabraian for an orthopedic consult and evaluated with a repair of rotator cuff musculature, left supraspinatus portion. A second rotator cuff repair was performed on 3/10/05, followed by further therapy. In April of 2005 the patient's

shoulder "popped" during therapy with immediate pain, treated with steroid injections to the shoulder. Psychotherapy sessions begun on 5/26/05. Negative arthrogram of the left shoulder on 5/26/05. Continued with therapy, then progressed or chronic pain management program.

A designated doctor's appointment on 9/19/05 determined the patient was clinical maximum medical improvement, with a 10% impairment.

REQUESTED SERVICE(S)

Physical therapy services: 97010 (hot-cold packs), 97032 (electrical stimulation), 97035 (ultrasound), 97110 (therapeutic exercises) for dates of service 6/23/05-07/27/05.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

The records demonstrate that the patient responded to care provided. This was a very complicated left shoulder problem, more complex than the "average" injuries and treatment parameters recommended by applicable treatment guidelines. The employment of adjunctive therapeutic modalities in conjunction with components of an active treatment platform were appropriate, especially in dealing with the complexities of such a postsurgical injury.

Sufficient improvement was noted by Dr. Fike with the therapy, goals were addressed with improvement in both range motion and strength.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

The Work Loss Data Institute's *Official Disability Guidelines, third edition 2005*

The American College of Occupational and Environmental Medicines *Occupational Medicine Practice Guidelines*,

The American Physical Therapy Association *Guidelines for Programs for Injured Worker's*, 1995

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the 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 decision before referral to the IRO.

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.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell