

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address San Antonio Accident/Injury Care 401 W. Commerce Suite # 100 San Antonio, Texas 78207	MDR Tracking No.: M5-05-1452-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 03	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
11-08-04	12-02-04	97124, 97112 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division 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 IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review 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	Debra L. Hewitt _____ Typed Name	06-22-05 _____ Date of Decision
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PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

**Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758**

Phone 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 20, 2005

Re: IRO Case # M5-05-1452 -01 ____

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. IME 11/18/04, Dr. Kennedy
4. Daily Chiropractic treatment log 11/8/04 – 12/2/04
5. Medical records, Concentra
6. MRI report left shoulder 7/27/04
7. Initial medical evaluation 8/9/04 and notes, Dr. Alexander
8. Medical records, Dr. Bustamante
9. FCE 9/21/04

History

The patient is a 57-year-old male who in ___ fell, landing on his shoulder. He first went to Concentra Medical Centers for treatment and was diagnosed with a shoulder strain. He was started on some physical therapy, then released from care on 7/12/04. The patient returned to Concentra on 7/20/04, complaining of left chest/armpit pain. Therapy treatment was restarted. An MRI of the left shoulder was performed on 7/27/04, revealing a full thickness tear of the rotator cuff with retraction of the musculotendinous junction, fluid in the subacromial and subdeltoid bursa, hypertrophy of the left acromioclavicular joint with moderate impingement on the subacromial space, and moderate degenerative joint disease. The patient's treating doctor referred him to an orthopedic surgeon. The patient instead went to a chiropractor on 8/9/04. The chiropractor referred the patient for orthopedic evaluation. Continued conservative treatment was recommended. The orthopedic surgeon did not think that surgery would benefit the patient. An FCE on 9/21/04 indicated that the patient was performing at a sedentary physical demand level in activities involving the injured area. Continued physical therapy was recommended. Physical therapy was continued until December 2004. Apparently, eventually surgery was recommended.

Requested Service(s)

Massage therapy, neuromuscular reeducation, therapeutic exercises 11/8/04 – 12/2/04

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient suffered a rotator cuff tear for which a trial of physical therapy would be appropriate. He began treatment with his D.C. on 8/9/04. Between 8/9/04 and 11/7/04, an eight week period, the patient went to physical therapy 32 times. Physical therapy beyond this eight week period would not be medically necessary. There would not be a need for continued supervised, formal therapy. The patient could have continued a home exercise program on his own.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

Daniel Y. Chin, for GP