

# 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 South Coast Spine and Rehabilitation, P.A. 620 Paredes Line Road Brownsville, Texas 78521	MDR Tracking No.: M5-05-2491-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Workers Compensation Solutions Box 19	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		
02-02-05	02-21-05	97035, 97113 (2 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
02-02-05	02-21-05	97124, 99213, 97113 (more than 2 units)	<input type="checkbox"/> Yes <input checked="" 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 **majority** of the disputed medical necessity issues. The amount due from the carrier for reimbursement for the medical necessity issues equals **\$725.84**.

### PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$725.84 consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision and Order by:

\_\_\_\_\_  
Authorized Signature

08-31-05

\_\_\_\_\_  
Date of Decision and Order

### 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**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution 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.

**Si prefiere hablar con una persona en 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

August 19, 2005

**Re: IRO Case # M5-05-2491 –01 \_\_\_\_**

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Texas Worker's Compensation cases. Texas HB. 2600, Rule 133.308 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. MRI reports right shoulder and lumbar spine 2/4/04
4. FCE 3/3/05
5. IR report 11/11/04, Dr. Howell
6. RME report 12/28/04, Dr. Heisey
7. Office notes 3/4/04 – 7/13/04 Dr. Lakshmikanth
8. Medical records 9/30/04 – 12/9/04, Dr. Tijmes
9. Medical records 9/13/04 – 3/1/05, Dr. Howell and Dr. Strong
10. Physical therapy notes 2/2/05 - 2/21/05

### History

The patient injured his right shoulder and low back in \_\_\_\_ when he was carrying a heavy door. He went to his D.C. and was evaluated and started in physical therapy. A 2/4/04 MRI of the right shoulder revealed an acute full thickness tear of the supraspinatus tendon with retraction. An MRI of the lumbar spine on the same day revealed mild degenerative facet joint hypertrophy on the left at L5-S1. The patient underwent right shoulder rotator cuff repair and open acromioplasty on 10/29/04. He was cleared to begin post-operative physical therapy on 2/19/05. The patient continued his post operative therapy through February 2005.

### Requested Service(s)

Aquatic therapy 97113, massage therapy 97124, office visits 99213, ultrasound 97035 2/2/05 –2/21/05

### Decision

I agree in part and disagree in part with the carrier's decision to deny the requested services.

### Rationale

I agree with the decision to deny codes 99213 and 97124. Evaluation and management services are not medically necessary at the time of each physical therapy visit. Treatment by a massage therapist is also not medically indicated in this case.

Occasionally after rotator cuff repair, massage by a physical therapist would be necessary to relieve muscle spasm and improve joint motion. According to the notes provided for this review, the patient was treated for 30 minutes by a massage therapist, and this would not be medically necessary.

I disagree with the denial of code 97035. Therapeutic ultrasound is an appropriate adjunct to therapeutic exercise following rotator cuff repair.

I disagree with the denial of 2 units per session of code 97113, and I agree with the denial of any more than 2 units per session of code 97113. The patient had a rotator cuff surgery on 10/29/04. This apparently had been an old injury, as the MRI showed retraction. The patient was cleared by his surgeon for active physical therapy on 12/9/04. Active therapy and exercises are an important part of recovery after rotator cuff surgery. Therapy lasting up to 12 weeks would not be unusual or inappropriate. One on one therapy treatment is important to protect the integrity of the repair while improving strength and range of motion. However, physical therapy sessions should not last beyond 45 minutes per session. This leaves two units, or 30 minutes of exercise to be performed. This is appropriate up to three times per week.

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

Sincerely,

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Daniel Y. Chin, for GP