



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Coastal Spine Medical Center 5327 S. McColl Road Edinburg, Texas 78539	MDR Tracking No.: M5-06-0262-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Zenith Insurance Company Box 47	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: DWC-60 dispute package
 POSITION SUMMARY: Per the table of disputed services "The care rendered to the patient has met criteria set by Texas Labor Code Section 408.21. Complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION: Response to DWC-60
 POSITION SUMMARY: Zenith continues to believe that the disputed services were not medically necessary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-30-04 to 02-25-05	99212, 97113, 97110, 97124, 97035, 97140, 99214, 97112-QB and 97750-FC	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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.

Dates of service 09-27-04 and 09-28-04 per Rule 133.308(e)(1) were not timely filed and will not be a part of the 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:

01-18-06

Authorized Signature

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.

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

REVISION IV – 1/17/06

TDI-WC Case Number:	
MDR Tracking Number:	M5-06-0262-01
Name of Patient:	
Name of URA/Payer:	Coastal Spine Medical Center
Name of Provider: (ER, Hospital, or Other Facility)	Coastal Spine Medical Center
Name of Physician: (Treating or Requesting)	Pete E. Garcia, MD

November 30, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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

CLINICAL HISTORY

Medical Records reviewed

1. EOB from carrier
2. Health care summary
3. Multiple HCFA 1500's and EOB's
4. Daily Office visits records
5. FCE
6. Operative note
7. MRI report
8. Excerpt of MFG (which is no longer valid)

This is a lady who reportedly slipped and fell while at work. She was diagnosed with a shoulder injury and sent for a MRI to evaluate the extent of the injury. On the date of the MRI she was evaluated again by Jesus Quintanilla, D.C. who felt that an eight week physical therapy protocol was warranted prior to establishing the diagnosis. On August 30, 2004 the MRI noted a rotator cuff tear and the physical therapy continued. On November 19, 2004 the claimant underwent shoulder surgery. In December a rehab course of aquatic therapy, joint mobilization, manual therapy and ultrasound was started. An FCE was completed in February and a work hardening program was suggested.

REQUESTED SERVICE(S)

Medical necessity of Office Visits (99212 & 99214), Aquatic Therapy (97113), Therapeutic exercise (97110), Massage (97124), Ultrasound (97035), Manual Therapy Technique (97140), Neuromuscular Re-education (97112-QB), FCE (97750-FC) for dates of service 9/30/04 through 2/25/05.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

The dates of service of 9/30/04 through 2/25/05 were not medically necessary as they did not objectify any improvement and there was discussion of a surgical intervention.

After the diagnosis of a rotator cuff tear that required surgical intervention was noted, this negated the need for physical therapy. Additionally the daily progress notes indicate no real change in condition or improvement clinically; there was continued weakness (4/5), and flexion/abduction in the 100 – 125 range consistently. This lack of improvement would create the need to alter the modalities offered. Thus the therapeutic measures from the date of MRI August 30, 2004 through the date of surgery are not clinically indicated. A position realized by Jesse Quintanilla, D.C. on October 7, 2004. However, after the surgery was done, and after several days of rest, a post-operative rehabilitation program would be indicated. Therefore, therapeutic exercise was medically necessary from November 19, 2004 – December 30, 004. This is the standard rehabilitation period after the surgical procedure completed.

The rehabilitation program begun in December (Aquatic therapy Massage, Ultrasound and joint mobilization) is not reasonable and necessary. As noted in both Krusen's and Wheeless; after a rotator cuff repair a gentle range of motion protocol is warranted. This gentle range of motion does not require aquatic measures as a simple wall crawling and pendulum exercise is all that is needed initially. Moreover, one does not have to manipulate the joint after the surgery so the joint mobilization, manual therapy and ultrasound were not clinically indicated. Daily physical therapy is excessive as the muscles would need time to rest and restructure. At most three times a week therapeutic exercise and range of motion training were indicated. With time the active resistive exercises are advanced to improve strength. Therapeutic exercises were and are warranted, the remainder is considered excessive.

Neuromuscular re-education is designed for significant lesion (mostly crippling) and this is not indicated for the routine post-operative rehabilitation of a shoulder injury. Review of the literature does not indicate that shoulder rehabilitation would require neuro-muscular re-education.

The purpose of a functional capacity evaluation is to establish the minimum abilities of the overall condition. In this case this injury was limited to a rotator cuff tear. The notes do not reflect if there was a job to return to, if there were any job requirements that would require such an evaluation. Based on the notes presented, it appears that this was done solely because it was a test that was available. If there is a clinical indication for this testing, it was not presented in the progress notes reviewed.

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