



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	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0767-01
Gabriel Gutierrez P.O. Box 229 Katy, TX 77492-0229	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Royal Insurance Company of America, Box 11	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, "Documentation provided to the adjustor and carrier was in compliance with the documentation requirements, CARF guidelines, as well as the documentation requirements that clearly and unequivocally document the medical necessity for Work Hardening."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response received.

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)
1-19-05 – 2-11-05	CPT code 97545-WH-CA (\$128.00 X 15 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,920.00
1-19-05 – 2-11-05	CPT code 97546-WH-CA (\$64.00 X 90 units)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$5,760.00
	Grand Total		\$7,680.00

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 prevail on the disputed medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$7,680.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).

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 carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$7,680.00. The Division hereby **ORDERS** the insurance carrier 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.

Findings and Decision by:

Donna Auby

2-21-06

Order by:

Margaret Ojeda

2-21-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0767-01
NAME OF REQUESTOR: Gabriel Gutierrez, D.C.
NAME OF PROVIDER: Juan Galvan, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 02/08/06

Dear Dr. Gutierrez:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician 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.

REVIEWER REPORT

Information Provided for Review:

X-rays of the right shoulder interpreted by Tom Clayton, M.D. dated 04/22/03
Evaluations with William F. Donovan, M.D. dated 05/12/03, 06/18/04, and 02/22/05
An MRI of the right shoulder interpreted by Dr. Clayton on 05/28/03
X-rays of the right shoulder and cervical spine interpreted by Dr. Donovan dated 06/17/03
Letters of medical necessity for a cervical MRI and physical therapy to the right shoulder from Dr. Donovan dated 06/17/03
An EMG/NCV study interpreted by S. Kahkeshani, M.D. dated 06/17/03
Letters of medical necessity for right shoulder surgery from Dr. Donovan dated 06/30/03 and 05/12/04
A letter of causation from Dr. Donovan dated 09/23/03

X-rays of the right shoulder interpreted by Dr. Donovan dated 04/05/04, 06/14/04, 06/25/04, 09/21/04, 11/10/04, and 02/22/05
An operative report from Dr. Donovan dated 06/17/04
Evaluations with Juan C. Galvan, D.C. dated 06/29/04, 07/15/04, 07/21/04, 07/30/04, 08/06/04, 09/10/04, and 10/06/04
A letter from CorVel dated 08/13/04
A Designated Doctor Evaluation with Gaston Machado, M.D. dated 09/07/04
A Functional Capacity Evaluation (FCE) with Wayne Parks, D.C. dated 10/18/04
A preauthorization request for work conditioning from Dr. Galvan dated 10/28/04
A recommendation for adverse determination from UniMed Direct, L.L.C. dated 11/10/04
A mental health evaluation with Monie G. Smith, M.A., L.M.F.T. dated 12/09/04
A vocational assessment with Phillip W. Roddy, M.S., C.R.C. dated 12/09/04
Work hardening reports with Gabriel R. Gutierrez, D.C. dated 12/21/04, 01/07/05, 01/18/05, 01/27/05, 02/03/05, and 02/11/05

Clinical History Summarized:

X-rays of the right shoulder interpreted by Dr. Clayton on 04/22/03 showed possible rotator cuff disease and probable mild osteoporosis. An MRI of the right shoulder interpreted by Dr. Clayton on 05/28/03 showed tendonitis/tendinosis of the supraspinatous and infraspinatous component of the rotator cuff tendon with a possible full thickness tear and mild impingement of the AC joint. X-rays of the right shoulder and cervical spine interpreted by Dr. Donovan on 06/17/03 revealed slight narrowing at C5-C6, some subluxation at C4-C5, and degenerative spurs anteriorly at C3-C6. An EMG/NCV study interpreted by Dr. Kahkeshani on 06/17/03 revealed sensory motor neuropathy of the upper extremities. X-rays of the right shoulder interpreted by Dr. Donovan on 04/05/04 revealed a rotator cuff tear. A right shoulder rotator cuff repair and distal clavicle resection at the AC joint was performed by Dr. Donovan on 06/17/04. On 06/29/04, Dr. Galvan recommended therapy three times a week for four weeks. On 07/21/04, Dr. Galvan provided an electrical muscle stimulator unit. On 08/06/04, Dr. Galvan recommended further therapy three times a week for two weeks. Dr. Machado felt the patient was not at Maximum Medical Improvement (MMI) as of 09/07/04. On 09/10/04 and 10/06/04, Dr. Galvan recommended further therapy, home exercises, and use of the electrical stimulator unit. An FCE with Dr. Parks on 10/18/04 determined the patient was functioning at the light physical demand level and a work conditioning program was recommended. A mental health evaluation with Ms. Smith on 12/09/04 showed the patient was an appropriate candidate for the work hardening program. The patient participated in work hardening with Dr. Gutierrez from 12/21/04 through 02/21/05 for a total of six weeks. On 02/22/05, Dr. Donovan felt the patient was at MMI at that time with a 7% whole person impairment rating.

Disputed Services:

A work hardening program from 01/19/05 through 02/11/05

Decision:

I agree with the requestor. The work hardening program from 01/19/05 through 02/11/05 was medically necessary to treat the patient.

Rationale/Basis for Decision:

According to the records reviewed, the patient was injured on _____. The patient ultimately had to have surgery to the right shoulder on 06/17/04. She began postoperative rehabilitation in July of 2004. She was then referred for a work hardening program from 01/19/05 through 02/11/05. According to the American Physical Therapy Association's Guidelines for work hardening programs, entrance criteria includes having a targeted job or job plan for return to work, a willingness to participate, an identified physical, functional, behavioral, and vocational deficit that interferes with work, and being at a point of resolution of the initial or principle injury, such as that participation in the program would not be prohibited. The records revealed the patient targeted her return to work to her previous job as an order picker. There was nothing in the records available for my review that stated the patient was not willing to participate in the work hardening program. The FCE on 10/18/04 showed the patient was functioning at the light physical demand level, which was below the level of her previous job that required the very heavy physical demand level. In addition, the patient had a mental health assessment on 12/09/04, which revealed that her status was appropriate for entrance into a work hardening program. Lastly, the patient had received four months of postoperative rehabilitation and was in the stage of treatment where a multidisciplinary program was an option if the patient met the criteria. In short, since the patient met the criteria for entrance into a work hardening program, the program from 01/19/05 to 02/11/05 was medically necessary to treat the patient.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

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. 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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 02/08/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel