



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:** ( ) Health Care Provider (X) Injured Employee ( ) Insurance Carrier

Requestors Name and Address:	MDR Tracking No.: M5-06-1731-01
Ergonomic Rehabilitation of Houston 283 Lockhaven Drive Suite 315 Houston, TX 77073	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:  Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

**PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

Requestor's Position Summary: "Our services fell within the parameters of the Official Disability Guidelines for this injury."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

**PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY**

DWC-60 Response received.

**PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services**

<u>Date(s) of Service</u>	<u>CPT Code(s) or Description</u>	<u>Medically Necessary?</u>	<u>Additional Amount Due (if any)</u>
6-1-05 – 11-29-05	CPT codes 97035, 97124, 97110, 97140	<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.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308  
Texas Labor Code 413.031

**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.

**Findings and Decision by:**

**Medical Dispute Officer**

7-24-06

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

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
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.**

**INDEPENDENT REVIEW INCORPORATED**

July 5, 2006

Re: MDR #: M5 06 1731 01 Injured Employee: \_\_\_  
DWC #: \_\_\_ DOI: \_\_\_  
IRO Cert. #: 5055 SS#: \_\_\_

**TRANSMITTED VIA FAX TO:**

**TDI, Division of Workers' Compensation**

Attention: \_\_\_

Medical Dispute Resolution

Fax: (512) 804-4868

**RESPONDENT:**

**REQUESTOR: Ergonomic Rehabilitation of Houston**

**TREATING DOCTOR: Allen Deutsch, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. 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 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in orthopedic surgery and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

## 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, 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.

Sincerely,

The image shows the handwritten initials 'jc' in a stylized, black, serif font. The 'j' is lowercase and has a dot, while the 'c' is uppercase and is a simple curve.

Jeff Cunningham, DC  
Office Manager

# INDEPENDENT REVIEW INCORPORATED

## REVIEWER'S REPORT M5 06 17631 01

### **Information Provided for Review:**

1. DWC assignment.
2. Multiple EOBs.
3. Nonauthorization request.
4. Records from Ergo Rehab.
5. Carrier's records and documentation.

### **Clinical History:**

The patient is a deputy sheriff who suffered a rotator cuff tear. He received some preoperative physical therapy that was authorized and paid for by the insurance company. Postoperatively after rotator cuff repair, he received approximately 2-1/2 months of physical therapy. The provider of the service billed 2 hours of therapy per session.

### **Disputed Services:**

Physical therapy services provided beyond the 1 hour per session have been denied as medically unnecessary by the insurance carrier.

### **Decision:**

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

### **Rationale:**

There is no documentation to support why this patient received therapy sessions in excess of 1 hour. Eighteen to 24 visits were authorized upon peer review, and I believe that that many visits are appropriate for a rotator cuff repair and the type of surgery this patient underwent. However, there is no reason that the patient needed more than 1 hour of therapy at each visit. Therefore, my recommendation is to agree with the insurance carrier that only 18-24 visits with 1 hour per visit are appropriate and necessary for this patient's rehabilitation.

### **Screening Criteria/Treatment Guidelines/Publications Referenced**

My experience as a fellowship-trained hand and upper extremity surgery who performs multiple rotator cuff repairs as well as the Journal of Hand Surgery, Journal of Shoulder and Elbow Surgery, and Orthopedic Knowledge Update, Shoulder and Elbow Edition, would all document and support this decision.