

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER: 453-05-9073.M5

## MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

### Retrospective Medical Necessity Dispute

#### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (X) No
Requestor's Name and Address Pain & Recovery Clinic of North Houston 6660 Airline Drive Houston, Texas 77076	MDR Tracking No.: M5-05-1629-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	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		
02-02-04	02-10-04	97140, 97112, 97110 (1 unit) and 99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
03-01-04	03-01-04	99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
04-05-04	04-05-04	99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
02-16-04	04-30-04	97140, 97112 and 97110 (1 unit)	<input checked="" 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 **prevailed** on the **majority** of disputed medical necessity issues. The reimbursement due from the carrier for the medical necessity issues equals **\$4,071.60**.

#### 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 entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services totaling \$4,071.60 in dispute 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 By:

Debra L. Hewitt

06-30-05

Typed Name

Date of Findings and Decision

Order By:

Margaret Ojeda

06-30-05

Authorized Signature

Typed Name

Date of 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**

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 27, 2005

**Re: IRO Case # M5-05-1629 -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, 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. Peer review 3/24/04, Dr. Tsourmas
4. Office notes, 10/13/03 – 6/10/04, Dr. Varon

5. Daily progress notes, Dr. Patel
6. Physical therapy progress notes
7. Medical records, Dr. McMillan
8. Medical records, Dr. Mohamed and Dr. Garrett
9. EMS report 10/11/03
10. Report x-ray right wrist 1/2/04
11. Report skull x-rays and brain MRI 1/19/04
12. Report cervical spine x-rays and MRI 1/19/04
13. Report x-rays right wrist and forearm 2/11/04
  
14. Report electrodiagnostic study 3/15/04
15. Report x-rays and MRI right wrist 4/21/04
16. Report x-rays right wrist and lumbar spine 10/11/03
17. Report x-rays right forearm and wrist 11/4/03

### History

The patient is a 46-year-old female who in \_\_\_ slipped and fell on wet cement. She injured her back and neck and sustained fractures of the radius and ulna. The patient was taken to the hospital, where x-rays were obtained. The x-rays showed non-displaced fractures. The patient was placed in a modified cast and directed to follow up with a hand surgeon on 10/13/03. The surgeon recommended continued non-surgical treatment with casting. The patient then began treatment with her treating doctor on 10/20/03. He started her on extensive physical therapy for her neck and upper back. She was also treated with chiropractic. Skull x-rays and a brain MRI were normal. An MRI of the cervical spine on 1/19/04 showed herniations at C4-5 and C5-6. Due to the patient's osteopenia and delayed rate of healing, she was kept in a cast and splint for several months. The patient's hand surgeon had her started on physical therapy for the hand and wrist on 2/12/04. The surgeon documented stiffness and limited range of motion. The surgeon recommended physical therapy to improve the patient's range of motion and strength. The patient was referred for pain management on 2/26/04, and electrodiagnostic testing of her upper extremities was recommended. EMG/NCS on 3/25/04 revealed carpal tunnel syndrome.

### Requested Service(s)

Therapeutic exercises, manual therapy technique, neuromuscular reeducation, OV 2/2/04 –4/30/04

### Decision

I disagree with the carrier's decision to deny one unit of therapeutic exercises, manual therapy technique and neuromuscular reeducation per session 2/16/04 –4/30/04. I agree with the decision to deny all other requested services.

### Rationale

I agree with the denial of the requested services 2/2/04 – 2/10/04 because the patient suffered an injury in \_\_\_ for which she had been treated with 39 sessions of physical therapy to her neck and low back. There was no need for continued, supervised, formal one on one physical therapy and the patient could have continued on a home exercise program.

The patient had documented severe decreases in range of motion and strength in her right wrist and hand due to her prolonged immobilization in a cast and splint. She was released to start physical therapy by her surgeon to improve range of motion and strength in her hand and wrist. This was medically necessary and appropriate. There was a documented increase in range of motion and

strength, showing that the patient was benefiting from the therapy. However, only one unit of each of the three physical therapy services per session would be medically appropriate.

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