



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: Denton Sports & P.T. Center 534 N. Elm Street Denton, Texas 76201	MDR Tracking No.: M5-05-2975-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 and explanation of benefits.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Explanation of benefits, CMS 1500s and response to TWCC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-18-04 to 10-14-04	97110	<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

PART VII: DIVISION DECISION AND ORDER

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:

09-26-05

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.

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

September 21, 2005

Re: IRO Case # M5-05-2975 –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 Workers’ Compensation cases). Texas HB. 2600, Rule133.308 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 cases be assigned to certified IROs, TWCC this case was assigned 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 Workers’ Compensation 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. Employers first report of injury ____
4. DDE 12/2/04, Dr. Connally
5. Physical therapy discharge summary 11/24/04
6. Minor emergency medical records 4/19/04 - 10/9/04
7. Radiology reports
8. Report MRI left knee 5/7/04, 11/8/04
9. Initial evaluation 5/17/04, Dr. Blair
10. Operative report 6/14/04, Dr. Blair
11. Office notes 6/1/04 – 11/16/04, Dr. Blair
12. Physical therapy notes 6/28/04 – 11/24/04
13. progress note 7/15/05, D. Phillips, P.T.
14. DDE 8/16/05, Dr. Lawson

History

The patient injured her left knee in ____ when she was descending a ladder, missed the last step, and came down hard on her left knee. On the same day, she also dropped a ladder on her right big toe. She was initially treated at a minor emergency center, where x-rays of her knee and toe were negative. The patient was treated with physical therapy, but she failed to progress and continued to have pain. A 5/7/04 MRI revealed a horizontal tear of the posterior horn of the medial meniscus. The patient was seen for orthopedic evaluation on 5/17/04 and conservative treatment was continued, but the patient failed to improve. On 6/14/04, the patient underwent arthroscopy with medial meniscectomy and lateral meniscectomy. She continued in physical therapy post-operatively until 11/24/04.

Requested Service(s)

Therapeutic exercises 8/18/04 – 10/14/04

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient underwent surgery for her torn meniscus on 6/14/04. Prior to surgery she had two months of physical therapy for the knee. After surgery, she had another two months on one on one physical therapy. The physical therapy report dated 8/6/04 reports the elimination of pain in the right great toe, 0/10 knee pain at rest, and a maximum of 5/10 knee pain. ROM in the left knee is reported as 0 – 121 degrees. No further physical therapy was recommended for the toe. At this point a patient should be discharged to a home exercise program. The records provided for this review do not document or establish a need for continued one on one active physical therapy. Therapy after a knee arthroscopy and meniscectomy beyond eight weeks post-operatively is not medically necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Workers' Compensation Division decision and order.

Sincerely,

Daniel Y. Chin, for GP