



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 Dispute

#### PART I: GENERAL INFORMATION

|                                                                                                                  |                                 |
|------------------------------------------------------------------------------------------------------------------|---------------------------------|
| <b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier                    |                                 |
| Requestor's Name and Address:<br>Monarch Pain Care Center<br>5151 Katy Freeway Suite 305<br>Houston, Texas 77007 | MDR Tracking No.: M5-05-3187-01 |
|                                                                                                                  | Claim No.:                      |
|                                                                                                                  | Injured Employee's Name:        |
| Respondent's Name and Address:<br>Hartford Casualty<br>Box 27                                                    | Date of Injury:                 |
|                                                                                                                  | Employer's Name:                |
|                                                                                                                  | Insurance Carrier's No.:        |

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

DWC package. Position Summary: Per table of disputed services "Medical Necessity"

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

No response received from Respondent.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

| Date(s) of Service   | CPT Code(s) or Description               | Medically Necessary?                                                | Additional Amount Due (if any) |
|----------------------|------------------------------------------|---------------------------------------------------------------------|--------------------------------|
| 07-19-04 to 08-30-04 | 97545-WH-CA (\$128.00 X 20 = \$2,560.00) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$7,312.00                     |
|                      | 97546-WH-CA (\$256.00 X 14 = \$3,584.00) |                                                                     |                                |
|                      | (\$192.00 X 3 = \$576.00)                |                                                                     |                                |
|                      | (\$160.00 X 1= \$160.00)                 |                                                                     |                                |
|                      | 97750-FC (\$432.00 X 1= \$432.00)        |                                                                     |                                |

#### 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 **prevailed** on the disputed medical necessity issues.

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

28 Texas Administrative Code Sec. 133.308 and 134.202

**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 entitled to additional reimbursement in the amount of \$7,312.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$650.00. 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:**

12-09-05

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

\_\_\_\_\_  
Date of Findings and Decision

**Order by:**

12-09-05

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

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

# Envoy Medical Systems, LP

1726 Cricket Hollow

Austin, Texas 78758

Fax 512/491-5145

Phone 512/248-9020

IRO Certificate #4599

## NOTICE OF INDEPENDENT REVIEW DECISION

November 14, 2005

Re: IRO Case # M5-05-3187 -01 \_\_\_\_

Texas Department of Insurance, Division of Workers' Compensation:

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 Division of Workers' Compensation cases. 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 cases be assigned to certified IROs, 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 Division of 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 the injured employee, the injured employee's employer, the carrier, the utilization review agent, 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. IM review 8/30/04
4. FCE 7/8/04
5. Initial psychological clearance 7/20/04, Dr. Lazar
6. Letter 11/16/04, Dr. Lazar
7. WH evaluation 7/19/04
8. WH records and progress notes 7/19/04 - 8/27/04

### History

The history in this case was taken from the peer review of 8/3/04, as clinical records were not provided for this review. The patient injured his right shoulder in \_\_\_\_\_. He reported acute onset of shoulder pain while carrying a cylinder head. X-rays were negative and the patient was diagnosed with impingement syndrome. An MRI showed tendinosis of the supraspinatus tendon, without tear. The patient was sent for physical therapy, but he re-injured his shoulder on the first visit. He underwent a subacromial injection, which improved his symptoms. On 1/22/03 subacromial decompression with rotator cuff repair was performed. He underwent post operative physical therapy. A 6/24/03 repeat MRI showed moderate tendinopathy, but no tear. Eventually, and MRI with gadolinium showed a SLAP lesion. Labral repair, bursectomy and distal clavical resection was performed on 3/3/04, followed by post-operative physical therapy. An FCE was performed on 7/8/04, and work hardening was recommended. The patient underwent psychological evaluation on 7/20/04, and behavioral modality intervention was recommended as part of the work hardening program.

Requested Service(s)

Work hardening and FCE 7/19/04 – 8/30/04

Decision

I disagree with the carrier's decision to deny the requested work hardening and FCE.

Rationale

A 7/8/04 FCE documented deficits in range of motion -- including shoulder adduction and abduction, lifting --including legs and lower and high near lift. It was noted on 7/20/04 that there was depression with irritable and flat affect, and poor insight, and pain disorder with psychological aspect was diagnosed. An interdisciplinary program with behavioral modality intervention was recommended. The patient showed some progress throughout the work hardening program, and reportedly successfully completed it. It is unknown if he was able to return to work at his regular job. However, based on the records provided, the work hardening program itself appears to be medically necessary and appropriate.

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

Sincerely,

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Daniel Y. Chin, for GP