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

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: Pain & Recovery Clinic of North Houston 6660 Airline drive Houston, Texas 77076	MDR Tracking No.: M5-06-0098-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Liberty Insurance Corporation Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package
POSITION SUMMARY: From the table of disputed services "All treatments & services were rendered in good faith to treat the injured employee's compensable injuries. The treatments were provided in conjunction with invasive pain management."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60 package
POSITION SUMMARY: Respondent did not submit a position summary

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-04-04 to 11-15-04	99212, 97110, 97140 and 97112	☐ Yes ☒ 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

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:

		11-18-05
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

November 17, 2005

Re: IRO Case # M5-06-0098 –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, 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, 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 insurance 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. Peer review 3/22/04, Dr. Hamby
4. Peer review 3/24/04, Dr. Harney
5. Preliminary Chiropractic review 8/25/04, Dr. Sage
6. Reconsideration 8/31/05, Dr. Antonelli
7. Initial evaluation 1/26/04, C. Meekins
8. Physical therapy progress notes 3/1/04 – 7/7/04, C. Meekin
9. Physical therapy progress notes 8/11/04 – 12/15/04, Dr. Patel
10. Daily progress notes 9/3/04 – 11/15/04
11. ESI operative report 4/15/04, Dr. Riberio
12. ESI, SI joint, and lumbar facet injection operative reports 5/04 – 12/04, Dr. Mohamed
13. Medical records including initial comprehensive evaluation and follow up notes 1/20/04 – 5/2/05, Dr. Mohamed
14. Discography report 4/27/05, Dr. Mohamed

History

The patient is a 37-year-old male who injured his low back in ___ while he was lifting 75-pound packages. As he attempted to lift a package, he felt an acute onset of pain in the low back. The patient was first seen by a company doctor, and then followed up with a pain management specialist. An MRI of the lumbar spine obtained on 3/15/04 reportedly showed disk protrusions at L4-5 and L5-S1. The patient was treated with physical therapy, but continued to have back pain. The patient underwent multiple bilateral L4-5 transforaminal epidural steroid injections, right and left SI joint injections, and right and left sides lumbar facet injections 4/15/04 – 12/8/04. The patient was reported to find relief from these injections, and radiofrequency was performed in January and February 2005. The patient's back and leg pain then worsened, and a lumbar discogram was performed on 4/25/05, which was positive for concordant pain at low pressures in the L5-S1 disk. Nucleoplasty was performed at L5-S1 on 5/25/05.

Requested Service(s)

Office visits, therapeutic exercise, manual therapy technique, neuromuscular re-education
9/4/04 – 11/15/04

Decision

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

Rationale

The patient suffered injury to his low back when attempting to lift a heavy box in . Physical therapy was appropriately started on 1/22/04. An initial course of physical therapy for weight weeks would be appropriate. At the conclusion of eight weeks of physical therapy, the patient should be independent in a home exercise program. At that point the patient can be discharged to continue exercises on his own. The medical necessity for continued physical therapy eight months after the initial injury has not been supported by the records provided for this review. The eventual spinal injection procedures are not indications for continued formal physical therapy.

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