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: Julio Fajardo, D.C. 2121 N. Main Street Fort Worth, Texas 76106	MDR Tracking No.: M5-06-0303-01 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 dispute package
POSITION SUMMARY: Per the table of disputed services "Medically necessary post-operative TX"

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: Requestor 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)
04-01-05 and 04-04-05	97110, 97140, G0283 and 97010 (see note below regarding reimbursement for 97010)	☒ Yes ☐ No	$471.69
08-08-05	99212	☐ 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 **prevailed** on the **majority** of the disputed medical necessity issues.

NOTE: No reimbursement for code 97010 is due as code 97010 is a bundled service code and considered to b e an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code. Therefore, additional payment cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and Rule 134.202(c)(1)

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 reimbursement in the amount of $471.69. 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 $460.00. 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.

Ordered by:

		12-27-05
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

Phone 512/248-9020 **Fax 512/491-5145**

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 6, 2005

Re: IRO Case # M5-06-0303 –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 Doctor of Chiropractic, who is licensed in Texas, 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. Reports 10/27/05, 3/3/05, and prescription for PT, Dr. Dillin
4. Request for reconsideration 8/1/05, Dr. Farjardo
5. Review 2/11/05, Dr. Soto
6. Medical reports, daily notes (including HICFs), PPE/FCE reports Dr. Farjardo
7. Report 11/4/05, Liberty Mutual

History

The patient injured her left shoulder in ___ after repetitive lifting and using her arms above her head. The patient's first doctor treated her with five weeks of physical therapy. The patient then sought chiropractic care from her treating D.C., who referred her to an orthopedic surgeon. The orthopedic surgeon recommended injections and MUA to the left shoulder, which were carried out. The orthopedic surgeon then referred the patient back to the D.C. for post MUA rehabilitation, which lasted about eight weeks. The patient's improvement was not satisfactory, and on 3/1/05 another MUA with injections was carried out. Four more weeks of post-MUA were recommended.

Requested Service(s)

Office visits, therapeutic exercises, manual therapy technique, hot/cold packs, electrical stimulation
4/1/05 – 8/8/05

Decision

I disagree with the carrier's decision to deny the requested services through 8/7/05, and I agree with the decision to deny services on 8/8/05 .

Rationale

Rehabilitation after the second MUA was medically necessary and follows the known protocol of post-MUA rehabilitation according to the National Academy of Manipulation Under Anesthesia Physicians. This second round of rehabilitation was recommended by the patient's orthopedic surgeon, based on the above-mentioned protocol, and on the good results from the first round of rehabilitation. The dates 4/1/05 and 4/4/05 would fall under the four-week rehabilitation program. Treatment on these two dates consisted of joint mobilization / PROM and myofascial release to improve mobility, circulation, break up scar/adhesion formation and decrease ligamentous adhesion, and myofascial trigger points. Documentation of decreased external rotation and shoulder flexion at end ROMs support this service. Documented increased ROM, including flexibility and mobility with decreased pain supports the services of 4/1/05 and 4/4/05. Daily notes and FCEs show continuing improvement in function and VAS pain scale.

A 4/21/05 FCE showed improvement in all planes of ROM, along with strength gains. On 3/3/05 the orthopedic surgeon noted that the patient "was substantially improved by her last 4-week exercise program.". However, in the 4/21/05 FCE during performance standards testing, which assesses dynamic tolerance to sitting, standing, repetitive lifting, carrying and extremity strength, the patient exhibited obvious fatigue, tremor, and a VAS of 6, noting increased pain. Static weight holding and walking showed good tolerance. The data suggested moderate muscular deconditioning, cardiovascular deconditioning and rapid fatigueability, thus failure to meet the lifting requirements for the patient's current job. Still, the patient's ROM, physical examination and strength data were consistent with the patient's mechanism of injury and post-surgical status; they would be considered good at this stage of the patient's rehabilitation. Although treatment was subjectively and quantitatively measured, and showed progression to return-to-work, a safe, full-duty return to the patient's job was not recommended without risk of further injury.

Based on the documentation provided for this review, the medical necessity of for continuing treatment was established.

No documentation was provided concerning the services on 8/8/05, and therefore, I agree with the decision to deny services on this date.

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