



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:
North Texas Pain Recovery Center
6702 W. Poly Webb Road
Arlington, Texas 76016

MDR Tracking No.: M5-06-0540-01

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: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "Treatment was medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "The attached dates of service were denied based on unnecessary medical with ANSI 50. No further payment was recommended towards the amount in dispute.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-18-05 to 05-31-05	97545-WHCA (1 unit @ \$128.00 X 9 DOS = \$1,152.00) 97546-WHCA (3 units @ \$192.00 X 4 DOS = \$768.00) 97546-WHCA (5 units @ \$320.00 X 2 DOS = \$640.00) 97546-WHCA (6 units @ \$384.00 X 3 DOS = \$1,152.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$3,712.00
06-01-05 to 06-03-05	97545-WHCA and 97546-WHCA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	TOTAL		\$3,712.00

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.

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 reimbursement in the amount of \$3,712.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$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.

Ordered by:

03-07-06

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

February 22, 2006

Re: IRO Case # M5-06-0540 -01 amended 3/7/06

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 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. Reviews 9/22/05, 7/11/05, PRI
4. IR report 6/20/05, Dr. Tran
5. FCE reports 4/14/05, 11/24/04 Work hardening notes 5/6/05 -5/31/05
6. Employers first report of injury
7. Medical records 5/27/04 - 9/24/04, 12/15/04, 3/5/05, 3/17/05, Med Alert Clinics
8. MRI right knee report 6/3/04
9. Initial orthopedic consult report 6/11/04, Dr. Haenke
10. RME 11/15/04, Dr. Beavers
11. Psychological screening evaluation
12. Clinical notes 12/29/05 - 3/2/05, Dr. Graybill
13. Electrodiagnostic test report 6/27/05
14. Physical therapy progress notes 9/2/04, 9/8/04
15. Physical rehabilitation evaluation 12/29/04
16. Pain management progress notes 2/15/05 - 6/7/05

History

In ___ the patient kneeled on her knees for 20-25 minutes to clean some shelves, and when she stood up she began having pain and swelling in the right knee. After obtaining an MRI, the patient was referred to and orthopedic surgeon on 6/11/04. The

orthopedic surgeon's impression was internal derangement with medial meniscus tear, right knee. Arthroscopic surgery was recommended, but was denied by the carrier. Physical therapy was attempted, but the patient was unable to tolerate the therapy and it was discontinued. The patient underwent an FCE and a psychological screening on 11/24/04. She was found to be very limited in her functioning. She was also diagnosed with adjustment disorder, depression, anxiety and chronic pain syndrome. The patient began treatment for pain management on 12/29/04, and began a chronic pain management program on 2/15/05. The patient progressed well and on 4/18/05 was discharged from the pain program and began a work hardening program. A 4/14/05 FCE reported that the patient was functioning close to the heavy work level, and was able to lift 50 pounds infrequently and able to lift 27.5 pounds frequently. She had an average endurance, moderate pace and minimal pain behavior. The patient worked as a sales associate, and her job duties included two hours standing, two hours walking, 50 pounds maximum lifting and 40 pounds lifting frequently. The patient had continued working as a greeter.

Requested Service(s)

Work hardening and work hardening each additional hour 5/18/05 – 6/3/05

Decision

I disagree with the carrier's decision to deny the requested services 5/18/05 –5/31/05 and I agree with the decision to deny the requested services 6/1/05 – 6/3/05.

Rationale

The patient had been unable to tolerate physical therapy. She made progress in a pain management program, and when she was able to tolerate more physical therapy was transitioned to a return to work, work hardening program for more aggressive physical therapy. Work hardening notes indicate slow but steady progress in her lifting capacity and psycho-social functioning. On 5/16/05 the patient was able to lift up to 30 pounds frequently, and 50 pounds occasionally. Knee range of motion was normal. On 5/31/05 the patient was able to lift and carry 45 pounds frequently, which exceeded her present job demands. Continued work hardening beyond this point would not be medically necessary. The records provided for this review do not document the necessity for continued treatment after 5/31/05.

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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing a decision (other than a spinal surgery prospective decision) the appeal must be made directly to a district court in Travis County (see Texas Labor Code 413.031). An appeal to the 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

Daniel Y. Chin, for GP