



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 and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Dallas Physical Performance Center 1108 Bally Mote Drive Dallas, Texas 75218	MDR Tracking No.: M5-06-1152-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Rep Box # 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute
 POSITION SUMMARY: Per the table of disputed services "denied per peer review, patient just had surgery and we have a refer from surgeon".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
 POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
04-25-05, 04-27-05, 04-29-05, 05-02-05, 05-04-05, 05-09-05 and 05-11-05	97110 (3 units @ \$108.42 X 7 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$758.94
04-25-05 to 06-01-05	97110 (greater than 3 units for DOS listed above and all units for DOS 05-17-05 to 06-01-05) and 99211	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
05-18-05	97750-P-PE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
TOTAL			\$758.94

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 majority of 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 \$758.94. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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:

05-18-06

Authorized Signature

Typed Name

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

May 2, 2006

Re: IRO Case # M5-06-1152 -01 amended 5/16/06

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. Carrier reviews 6/14/05, 2/21/05
4. Report of medical evaluation 2/22/05, 5/6/05, Dr. Spinks
5. H & P report 11/1/04, Operative report 11/5/04, Discharge summary 11/05, handwritten follow-up notes 11/18/04 -5/10/05, Dr. Myles
6. Notes 2/15/05 -5/10/05, Dr. Njamfa
7. Psychological evaluation 2/25/05, Dr. Rudick-Davis

History

The patient slipped and fell on ice in ____, injuring his low back. He was treated conservatively with physical therapy and epidural steroid injections. Failing conservative care, he underwent laminectomy and discectomy at L5-S1, with posterior interbody fusion at L4-5 and L5-S1. He later started having significant pain in his low back that radiated down the right leg. Again failing conservative care, he underwent hardware removal and exploration of fusion at L4-5 and L5-S1, partial repeat laminectomies at L4-5 and L5-S1 on the right, posterior lateral fusion of L4-5 and L5-S1, with instrumentation on the right on 11/5/04. He was given a prescription for aquatic therapy on 12/21/04, but was unable to start until 2/11/05, due to a delay in insurance approval. On 2/15/05 the patient was referred for pain management.

Requested Service(s)

Therapeutic exercises. Office visit, 97750-P-PE 4/25/05 - 6/1/05

Decision

I disagree with the carrier's decision to deny three units of therapeutic exercises on 4/25, 4/27, 4/29, 5/2, 5/4, 5/9, and 5/11/05. I agree with the carrier's decision to deny the remainder of the requested services.

Rationale

The patient underwent spinal surgery in November 2004. He began his post-surgical rehabilitation on 2/11/05. By 5/11/05, he had completed three months of post-operative rehabilitation. The records provided for this review did not document the medical necessity of physical therapy beyond this time period. After three months, the patient could have been discharged to a home exercise program to continue exercises on his own. Current Medicare guidelines limit physical therapy to three, 15-minute units of treatment per physical therapy session, no more than three times per week on non-consecutive days. Evaluation and management is not necessary for a patient at the time of physical therapy treatment.

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