



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>North Texas Pain Recovery Center<br>6702 W. Poly Webb Road<br>Arlington, Texas 76016 | MDR Tracking No.: M5-06-1164-01 |
|   | Claim No.:                      |
|   | Injured Employee's Name:        |
| Respondent's Name and Address:<br>Liberty Mutual Fire Insurance<br>Rep 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  
POSITION SUMMARY: Per the table of disputed services "medically necessary"

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

DOCUMENTATION SUBMITTED: Response to DWC-60 dispute  
POSITION SUMMARY: "Denied per peer review as not medically necessary".

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

| Date(s) of Service   | CPT Code(s) or Description      | Medically Necessary?  | Additional Amount Due (if any) |
|----------------------|---------------------------------|---|--------------------------------|
| 08-03-05 to 08-18-05 | 97545-WH-CA (\$128.00 X 12 DOS) | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$1,536.00                     |
|                      | 97546-WH-CA (\$384.00 X 12 DOS) |   | \$4,608.00                     |
| <b>TOTAL</b>         |                                 |   | <b>\$6,144.00</b>              |

#### 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 reimbursement in the amount of \$6,144.00. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$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.

**Findings and Decision by:**

05-19-06

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

\_\_\_\_\_  
Typed Name

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

**Order by:**

05-19-06

\_\_\_\_\_  
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 16, 2006

Re: IRO Case # M5-06-1164-01 \_\_\_\_

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 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. Review 9/2/05, Dr. Milton
4. Clinical note 8/5/05, Dr. Graybill
5. Behavioral Health Assessment 7/27/05, Dr. Walker
6. Work hardening daily treatment notes 8/3/05 – 8/18/05
7. FCE 8/5/05
8. Work hardening discharge summary 8/22/05

### History

The patient injured her low back in \_\_\_\_ when she was bending over to pick up an approximately 100-pound object. She was treated with a three-month course of physical therapy that did not help. She was also treated with aquatic therapy, which gave only temporary improvement. She was then evaluated with an FCE, and was found to be functioning at a sedentary physical demand level. The job to which she would return required a medium to heavy physical demand level. The patient attempted a work hardening program 8/3/05 – 8/18/05. She failed to progress, and even showed some regression. Therefore, she was discharged from the work hardening program, and enrolled in a pain management program.

### Requested Service(s)

Work hardening program 8/3/05 – 8/18/05.

Decision

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

Rationale

The patient's FCE and behavioral health assessment documented deficits that prevented her from returning to work. Although she had been let go from her previous position, it appears from the records provided for this review that there was a possibility of her being rehired to the position. The patient initially improved, but then started to regress, and she was appropriately discharged from the work hardening program. The 12-day trial of the work hardening program was medically necessary and appropriately.

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