



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: Dr. Tommy Overman/Russell Blaylock, OTR 6161 Harry Hines Blvd Suite 105 Dallas, Texas 75235	MDR Tracking No.: M5-06-1184-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Insurance Corporation 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 package

POSITION SUMMARY: Per the table of disputed services "Dispute over the appropriateness of work hardening program. We believe it to have been appropriate-letter responding to peer review or retrospective review".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "Charges denied per peer reviews enclosed".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
08-29-05 to 09-23-05	97545-WH-CA (1 unit @ \$128.00 X 14 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,792.00
	97546-WH-CA (5.5 units @ \$352.00 X 2 DOS)		\$704.00
	97546-WH-CA (6 units @ \$384.00 X 8 DOS)		\$3,072.00
	97546-WH-CA (4 units @ \$256.00 X 4 DOS)		\$1,024.00
TOTAL			\$6,592.00

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 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 \$6,592.00. 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.

Findings by:

06-01-06

Authorized Signature

Typed Name

Date of Findings and Decision

Order by:

06-01-06

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 27, 2006

Re: IRO Case # M5-06-1184 -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. Peer review 10/3/05, Dr. Grant
4. Peer review 6/15/05, Dr. Sato
5. Peer review 3/15/05, Dr. Sage
6. Peer reviews 1/4/06, 10/14/04, Dr. Antonelli
7. Request for reconsideration 11/14/05, Dr. Overman
8. RME 10/6/05, Dr. McCaig
9. Psychiatric interview 8/24/04, Dr. Overman
10. FCE summary report 8/25/05
11. Work hardening program records, Dallas Spinal Rehabilitation Center
12. MRI of lumbar spine report 2/3/05
13. Medical records, Dr. Grant
14. Procedure note re facet injections 5/31/05, Dr. Willis
15. Diagnostic test reports 2/2/05, 3/10/05
16. FCE reports 8/15/05, 8/25/05
17. TWCC work status reports

History

The patient was carrying some packages down a ramp in ____, when she felt the sudden onset of low back pain. She was treated with physical therapy and facet injections, which gave her only temporary relief. She underwent psychiatric evaluation on 8/24/05 and was diagnosed with pain disorder associated with psychological factors and general medical condition. The patient was also described as having depression. An 8/25/05 FCE demonstrated a sedentary physical demand level, with a necessary return-to-work physical demand level of medium/heavy. The patient began a work hardening program on 8/29/05. During the course of the work hardening program she underwent epidural steroid injections. Her work hardening program was terminated after four weeks for further diagnostic testing, including a possible discogram.

Requested Service(s)

Work hardening program 8/29/05 – 9/23/05

Decision

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

Rationale

When the patient started the work hardening program she was rated at a sedentary physical demand level. By the end of week three, she was rated at a light physical demand level. She also had doubled the amount of functional lifting in all categories. She had met all but one of eight goals at the end of week three, and she had met five out of seven goals by the end of week four. Her psychological evaluation identified psychological abnormalities that necessitated a multi-disciplinary work hardening program, including counseling. Although the validity of her effort in the FCE was in question, the progress that she made in the work hardening program demonstrates that it was medically necessary and appropriate.

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