



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: Santiago Guajardo, D.C. 3303 W. FM 1960 Suite 360 Houston, Texas 77068	MDR Tracking No.: M5-07-0182-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Argonaut Southwest Insurance Rep Box # 17	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Treatment medically necessary for extent of injury/post-operative status (as per medical documentation/Diagnostics) TX. Labor Code/Sect. 408.021."

Principle Documentation:

1. DWC 60/Table of Disputed Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a Position Summary

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-05-05 to 03-03-06	99213, 97110, 97112, 97140, 97035, 97750-FC and 99080-73	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
TOTAL DUE			\$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 **did not prevail** on the disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.1
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS AND DECISION

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 not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

01-09-07

Authorized Signature

Typed Name

Date of Findings and Decision

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**

PH. 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 28, 2006

Re: IRO Case # M5-07-0182 -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 the Division of Workers' Compensation assign cases 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 Orthopedic Surgery, is Fellowship trained in Hand Surgery, 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 injured employee's 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. Operative reports 8/9/05, 2/15/05
4. Occucare Occupational Medicine reports
5. Employer's first report of injury
6. RME 6/16/05, Dr. Reid
7. Peer review 10/18/05, Dr. Seymour
8. Records, Northside Pain Relief Center
9. Record, Synergy Chiropractic and Wellness Center, including FCE reports 2005
10. Records and reports 2003, 2004
11. Therapy prescription for ROC 8/16/05
12. ROC Reconstructive Orthopedic Center of Houston treatment notes 2005.

History

The patient suffered an index finger laceration in 2003 while working as a framer / construction worker, when a piece of metal weighing 5 – 8 pounds fell from a distance of about 20 feet high onto his right hand and index finger. He suffered significant problems with the index finger, including contractures and scarring, requiring multiple operations, releases and tendon reconstructions. This led to chronic pain and severe dysfunction of the hand. The patient also received therapy from certified hand specialists. The patient received the last of his surgeries, a second stage flexor tendon reconstruction, on 8/9/05. On 9/2/05 the surgeon recommended that the patient continue formal therapy at ROC. On 11/4/05 the surgeon stated that the patient "has adhered his tendon due to a lack of ability to have a certified hand therapist treat him...I do not believe therapy will help him as he lost the window of opportunity of avoiding the scar." On 12/9/05, the surgeon noted that, "therapy is not going to improve his condition." He was last seen by his surgeon on 8/7/06, at which time the surgeon determined that the patient's condition was permanent and stationary, and did not require further therapy, treatment or surgery. He was instructed to follow up on an as-needed basis.

Requested Service(s)

Office visit, therapeutic exercises, neuromuscular reeducation, manual therapy technique, ultrasound, functional capacity evaluation, DWC-73 report 10/5/05 – 3/3/06

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

Therapy for this type of injury, if necessary, should only be performed by a certified hand specialist. This sort of complex hand reconstruction cannot be rehabilitated by chiropractic treatment. Chiropractic treatment was not indicated, appropriate or warranted during any of the post-operative course for this patient's complex injury

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

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have a 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 the district clerk in Travis County (see Texas Labor Code sec. 413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.