

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? (X) Yes () No
Requestor's Name and Address Mark C. Sherrod, D.C., P.A. 5406 Winners Circle Amarillo, Texas 79110	MDR Tracking No.: M5-05-2336-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Box 28	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
07-01-04	12-30-04	98941, G0283, 97035 and 97012	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Per Rule 133.308(e)(1) date of service 04-27-04 was not timely filed and will not be part of this review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **prevailed** on the disputed medical necessity issues.

PART IV: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount totaling \$454.50 for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature

Typed Name

06-14-05

Date of Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

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

June 13, 2005

Re: IRO Case # M5-05-2336 -01 ____

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). 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 TWCC assign cases to certified IROs, TWCC assigned this case 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 Doctor of Chiropractic who is licensed in Texas, and who has met the requirements for the TWCC 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 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. Letter from carrier to IRO 5/24/05
4. Review, 10/6/04, Dr. Soto
5. Review, 5/4/03, Dr. Sage
6. SOAP notes, Dr. Sherrod
7. TWCC 69
8. Patient questionnaire, Dr. Sherrod

History

The patient injured his lower back and hip in ____ when he stepped out of a ____ truck. He was treated by the treating D.C. and released. Since then the patient has had recurring episodes of pain from the original injury that required treatment.

Requested Service(s)

Chiropractic manipulative treatment, spinal 3-4 regions, elec stimulation, ultrasound, mechanical traction 7/1/04 – 12/30/04

Decision

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

Rationale

It is well documented by the D.C. that the patient has continued to have exacerbation of his original injury. These exacerbations have been the result of normal ADL's and work activities. It is documented that the supportive / corrective care for the acute exacerbations was necessary to relieve the effects of the exacerbations. An adequate clinical evaluation was performed in every instance, with objective findings and subjective complaints that supported treatment. The documentation shows measured, objective improvement with treatment directed at return-to-work or maintaining work activity, provided in the least intensive and most cost-effective setting. The documentation also indicates that the patient showed strong independence with the will to manage and improve his condition personally, and that the patient had been consistently directed to active home management. The records provided for this review do not show evidence of over utilization, or inappropriate care, or a move towards doctor dependency. The D.C.'s documentation is excellent, and shows that treatment was reasonable and necessary with each visit, and that the treatment relieved the effects of the exacerbations.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

Daniel Y. Chin, for GP