



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:	MDR Tracking No.: M5-05-2501-01
James Todd Boyd DC DABCO 2310 N Expressway 83 Brownsville TX 78526	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Liberty Mutual Box 28	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DWC-60 package. Position Summary: IW wants to reduce the amount of medication and hence came to chiropractic care as the alternative to drugs.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position Summary: Unnecessary treatment with peer review.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
5-17-04 to 12-22-04	98940 x 46 days @ \$31.35 = \$1,442.10 97140-59 x 1 day @ \$31.73 = \$31.73 97535 x 1 day @ \$35.54 = \$35.54 99212-25 x 1 day @\$32.00 = \$32.00 99214-25 x 1 day @ 92.30 = \$92.30 99214-25 x 4 days x \$96.91 = \$387.64	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$2,021.31
1-3-05 to 2-10-05	98940 x 6 days @ \$31.35 = \$188.10 99214-25 x 1 day @ 96.91 = \$96.91	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$285.01
8-18-04	99361 x 1 day = DOP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
5-17-04 to 2-10-05	97039 x 52 days = DOP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	DOP
	Total		\$2,306.32 + DOP codes

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.

Dates of service 8-3-04 & 1-27-05 were listed on the table of disputed services; however, no bills were submitted to support these charges and neither party submitted an EOB. Therefore, no review will be conducted for these two dates of service.

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

necessity issues. For DOP codes, Subsection 134.202 (c) (6) of the MFG requires carriers to “assign a relative value, which may be based on nationally recognized published relative value studies, published (DWC) medical dispute decisions, and values assigned for services involving similar work and resource commitments.” The MAR for 99361 and 97039 is the amount assigned by the carrier that is consistent with the requirements of this rule.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 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 additional reimbursement in the amount of \$2,306.32 plus DOP codes. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of \$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.

Ordered by:

_____, Medical Dispute Officer

1-12-06

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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-05-2501-01
NAME OF REQUESTOR: James Todd Boyd, D.C.
NAME OF PROVIDER: James Todd Boyd, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 08/12/05 (REVISED 01/09/06)

Dear Dr. Boyd:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Licensed in the area of Chiropractics and is currently listed on the DWC Approved Doctor List.

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An orthopedic and neurological examination performed by an unknown provider (no name or signature was available) dated 04/15/04
Chiropractic treatment with James Todd Boyd, D.C. on 04/15/04, 04/16/04, 04/19/04, 04/21/04, 04/23/04, 04/27/04, 04/28/04, 04/30/04, 05/03/04, 05/05/04, 05/07/04, 05/10/04, 05/13/04, 05/17/04, 05/19/04, 05/21/04, 05/24/04, and 05/26/04

A referral for medication management to Dr. Diaz (credentials were not provided) dated 05/07/04 from Dr. Boyd

Another orthopedic and neurological examination from the unknown provider dated 05/19/04

Continued treatment with Dr. Boyd on 06/01/04, 06/02/04, 06/04/04, 06/11/04, 06/14/04, 06/16/04, 06/21/04, 06/25/04, 06/28/04, 07/02/04, 07/06/04, 07/09/04, 07/12/04, 07/16/04, 07/19/04, 07/21/04, 07/23/04, 07/26/04, and 07/30/04

Additional orthopedic and neurological examination from the unknown provider dated 07/02/04 and 08/16/04

Additional treatment notes from Dr. Boyd on 08/02/04, 08/05/04, 08/11/04, 08/16/04, 08/18/04, 08/23/04, 08/26/04, 08/30/04, 09/02/04, 09/07/04, 09/09/04, 09/13/04, 09/17/04, 09/20/04, 09/24/04, and 09/29/04

A prescription for an EMS unit, moist hot pad, and a whirlpool from Dr. Boyd dated 09/02/04

Additional orthopedic and neurological examinations with the unknown provider dated 10/13/04, 11/17/04, and 12/16/04

Continued treatment on 10/06/04, 10/13/04, 10/20/04, 11/03/04, 11/10/04, 11/17/04, 11/24/04, 12/02/04, 12/08/04, 12/16/04, 12/22/04, 01/03/05, 01/12/05, and 01/19/05 with Dr. Boyd

Further orthopedic and neurological examinations from the unknown provider dated 01/19/05 and 02/16/05

Additional chiropractic treatment dated 01/27/05, 02/02/05, 02/10/05, and 02/16/05 with Dr. Boyd

A letter "To Whom It May Concern" from Liberty Mutual dated 07/15/05 and signed by Virginia Cullipher, R.N.

Clinical History Summarized:

Dr. Boyd noted on 04/16/04 the claimant had a previous lumbar surgery and posterior laminectomy and fusion from L3-S1 and there was degenerative spondylosis present at L5-S1, as well as facet arthrosis at L3-L4. The claimant stated she had pain on a daily basis and had been taking Hydrocodone, Skelaxin, and Cyclobenzaprine on a daily basis for several years. The claimant attended chiropractic treatment with Dr. Boyd from 04/15/04 through 02/16/05. On 07/15/05, Ms. Cullipher at Liberty Mutual addressed a letter "To Whom It May Concern". She noted when the claimant changed treating physicians to Dr. Boyd in April 2004, she began treatment at a level more appropriate for the acute phase of her injury. All the treatment she received was passive in nature and unsubstantiated for necessity with objective findings.

Disputed Services:

Unlisted modality, chiropractic manipulative treatment, manual therapy technique, self-care management, office visits, and medical conference with the physician from 05/17/04 through 02/16/05

Decision:

I disagree with the insurance carrier. I feel that the unlisted modality, chiropractic manipulative treatment, manual therapy technique, self-care management, office visits, and medical conference with physician from 05/17/04 through 02/16/05 were reasonable and necessary.

Rationale/Basis for Decision:

The supplied documentation did demonstrate that the claimant presented to Dr. Boyd's office in significant distress as related to the injury that occurred on _____. The claimant's injury was severe enough that the claimant underwent spinal surgery on 05/31/01. Based upon the supplied documentation, she continued to suffer from chronic pain, which was treated by multiple medications, including narcotics, for an extended period of time. Treatment notes provided by Dr. Boyd showed the claimant's condition continued to progress, which caused her quality of life to improve, and allowed her to return to work. Section 408.021 (31 of the Texas Labor Code) substantiated the need for care following a work related injury, which cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. As previously mentioned, the documentation supplied did substantiate the care provided by Dr. Boyd on 05/17/04 through 02/16/05 did, in fact, qualify in meeting the requirements of 408.021 (31 of the Texas Labor Code), thereby making it reason, necessary, and causally related to the original injury. As a result of the treatment provided by Dr. Boyd, the claimant was able to significantly reduce her reliance upon those medications and her quality of life appeared to have significantly increased, thereby making her more functional and allowing her to remain employed.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician consulting for Professional Associates is deemed to be a Division decision and order.

YOUR RIGHT TO REQUEST A HEARING

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 the 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 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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to DWC via facsimile or U.S. Postal Service on 01/09/06 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel