



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

PREVAILING PARTY DETERMINATION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Main Rehab & Diagnostics 3500 Oak Lawn Suite 380 Dallas, Texas 75219	MDR Tracking No.: M5-05-2835-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

Consistent with the requirements in Rule 133.308, the Division has reviewed the IRO decision and determined:

- The requestor is the prevailing party.
- The respondent is the prevailing party.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-20-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99213 dates of service 08-02-04 and 08-03-04 were listed on the table of disputed services. Per Rule 133.307(e)(2)(A) the requestor did not provide copies of CMS 1500's as proof of submission to the carrier for payment. No reimbursement is recommended.

Review of CPT codes 97110-QU-GP and 97032-QU-GP date of service 08-02-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

PART III: ADDITIONAL INSTRUCTIONS

The parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. If the requestor was the prevailing party, the carrier must refund the amount of the IRO fee to the requestor within 30-days of receipt of this order.

Issued by:

09-08-05

Authorized Signature

Typed Name

Date of Decision

Envoy Medical Systems, LP

1726 Cricket Hollow

Austin, Texas 78758

Fax 512/491-5145

Phone 512/248-9020

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 30, 2005

Re: IRO Case # M5-05-2835 –01 _____

Texas Worker's Compensation Commission:

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 Texas Worker's Compensation cases). Texas HB. 2600, Rule133.308 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. TWCC 69 and D.D. evaluation 9/14/04, Dr. Tonn
4. Letter from carrier 8/4/05
5. Records from Occucare Medical Center
6. Treatment notes, Dr. Bedford
7. MRI lumbar spine report 6/25/04
8. Letter of medical necessity 7/1/05, Dr. Bedford
9. FCE 8/13/04
10. Report 8/26/04, Dr. Glickfeld

History

The patient injured his lower back in ____ when he lifted a metal plate and lost his balance, but did not fall. After initial treatment at a medical center, the patient sought chiropractic care.

Requested Service(s)

Office visits, massage therapy, manual therapy technique, therapeutic exercises, mechanical traction, electrical stimulation, and group therapeutic procedures 7/20/04 – 8/12/04

Decision

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

Rationale

The patient received an extensive amount of passive and active therapy prior to the dates in this dispute. The notes provided for this review indicate that the patient responded well to treatment prior to the dates in dispute. As a patient improves with treatment, the intensity and frequency of services should decrease, and that did not occur in this case. Based on the patient's response to treatment, the treatment was too intense and over utilized.

As of 7/12/04, the patient reached a plateau and further treatment failed to be of any significant benefit. If an individual's expected restoration potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, the services would not be reasonable and necessary.

Based on the records provided for review, there is no reason that the patient could not have been independent on a home-based exercise program after 7/12/04. There is no identifiable subjective or objective information to support monitored therapy after 7/12/04. Overall, there is no reason discernable as to why therapy should have continued, or as to what benefit was obtained. There must be some demonstrated benefit from therapy in order to establish medical necessity, and this was not the case after 7/12/04.

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

Sincerely,

Daniel Y. Chin, for GP