



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: Southeast Healthcare Services P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-05-2856-01
	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: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided: TWCC-60, explanation of benefits, medical documentation and CMS 1500s. Position summary: The patient went to a Designated Doctor (DD) appointment on 7-2-2004. He recommended that the patient have an MRI done on the lumbar spine and recommended that the patient continue the therapeutic exercises. He deferred MMI to 10-13-2004. The patient continued the prescribed treatment plan and responded well, she actually completed the program one month earlier on 9-9-2004. Based on the positive MRI findings and the recommendation of the DD to complete treatment. Please reconsider these dates of service for payment.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation provided: Response to TWCC-60 and explanation of benefits. Position summary: This dispute involves the carrier's payment of dates of service 7-1-2004 to 9-9-2004. The requester billed \$2,520.00; Texas Mutual paid \$0.00. The requester believes it is entitled to an additional of \$2,392.48.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
7-1-04 to 9-9-04	98940, 97140-59 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$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.

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. The dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 08-04-05, 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 99211 date of service 08-17-04 denied with denial codes –858-(physical medicine and rehabilitation services may not be reported in conjunction with an E/M code performed on the same day and –864- (E/M services may be reported only if the patient’s condition requires a significant separately identifiable E/M service. Per the 2002 Medical Fee Guideline code 99211 is allowed to be billed in conjunction with codes 97110 and 97140-59 billed on date of service 08-17-04. Reimbursement per Rule 134.202(c)(1) is recommended in the amount of **\$27.86 (\$22.29 X 125%)**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.133.308 and Rule 134.202(c)(1)

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 \$27.86 in regards to the fee issues. The Division finds that the requestor was not the prevailing party in the disputed medical necessity issues and is not entitled to a refund of the IRO fee. 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:

09-20-05

Authorized Signature

Date of Decision and 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
IRO Certificate #4599**

Fax 512/491-5145

NOTICE OF INDEPENDENT REVIEW DECISION

September 8, 2005

Re: IRO Case # M5-05-2856 –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, 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 cases be assigned to certified IROs, this case was assigned 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 Worker's 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 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. Carrier statement 8/18/05
4. Treatment and exam notes and exercise sheets, Dr. Weddle
5. Reports, 6/1/04, 6/22/04, Dr. Witlis
6. MRI lumbar spine report 7/16/04
7. EMB/NCV exam report 7/21/04
8. TWCC 69 reports
9. D.D. reports 7/13/04, 1/4/05
10. Report 7/16/04
11. TWCC work status reports

History

The patient injured her lower back in in ___ when she lifted a box of videos. The patient sought chiropractic care and was treated with therapeutic exercises and manipulation. The patient was also evaluated with MRI and EMG.

Requested Service(s)

Chiropractic manipulation, manual therapy technique, therapeutic exercises 7/1/04 – 9/9/04

Decision

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

Rationale

The patient received an adequate trial of conservative treatment prior to the dates in this dispute with good results. Based on the records provided for this review, the patient had a lumbar strain injury superimposed on multiple levels of disc degeneration. Six to eight weeks of care should resolve a lumbar strain injury, in this case that would have been by 7/1/04. The patient was placed at MMI on 7/22/04. As of this date, the D.C. noted that the patient's VAS was 0/10. On 6/1/04, the D.C. reported that the patient's VAS was 0/10 to 3/10. If an individual's expected restoration potential is insignificant in relation to the extent and duration of the treatment required to achieve such potential, the services would not be considered reasonable and necessary. The records provided for review show no reason why this patient could not have been independent on a home exercise program prior to the dates in this dispute. The D.C.'s notes lack objective, quantifiable findings to support the treatment in this dispute.

After an MMI date is reached, all further treatment must be reasonable and effective in relieving symptoms and improving function. The patient failed to show any improvement past 7/1/04. Services after this date exceeded criteria established for severity of injury, intensity of services and appropriateness of care for a lumbar strain injury. In the absence of documented continuing benefit, the medical necessity of the reviewed services is not established.

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

Sincerely,

Daniel Y. Chin, for GP