



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

CORRECTED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION
Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Kayce A Frye DC 5110 McPherson Suite 6 Laredo TX 78041	MDR Tracking No.: M5-05-3170-01
	Claim No.:
	Injured Worker's Name:
Respondent's Name and Address: TPS Joint Self Insurance Fund Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

TWCC-60 package, EOBs, CMS-1500s. Position Summary: "... We have treated [IW] conservatively, with passive modalities then moved into active therapy to include exercises and stretching/strengthening exercises as well. She has shown good improvement; she is at work full time but with limited duty..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documentation submitted: TWCC-60 response. No Position Summary submitted.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-1-05 to 3-16-05	97110 - \$67.20 x 14 days	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$939.68
	97530 - \$69.30 x 14 days	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$970.20
	98942 - \$57.18 x 14 days	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$800.52

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.

This CORRECTED Findings and Decision supercedes the previous Decision rendered in this medical payment dispute involving the above requestor and respondent.

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

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202

PART VII: CORRECTED 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 \$2,710.40. 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

11-18-05

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 Corrected and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the CORRECTED 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: M5-05-3170-01
NAME OF REQUESTOR: Kayce A. Frye, D.C.
NAME OF PROVIDER: Kayce A. Frye, D.C.
REVIEWED BY: Board Certified in Chiropractics
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 09/20/05

Dear Dr. Frye:

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 Board Certified in the area of Chiropractics and is currently listed on the TWCC 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 and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

Chiropractic treatment with Kayce A. Frye, D.C. on 01/06/05, 02/01/05, 02/02/05, 02/14/05, 02/18/05, 02/23/05, 02/24/05, 02/25/05, 02/28/05, 03/02/05, 03/04/05, 03/09/05, 03/11/05, and 03/16/05
TWCC-73 forms from Dr. Frye on 01/07/05, 01/26/05, and 06/03/05
An MRI of the lumbar spine interpreted by James E. Remkus, M.D. on 02/03/05
A letter of medical necessity for a TENS unit from Dr. Frye on 03/17/05
A request for reconsideration for chiropractic treatment from Dr. Frye on 04/06/05 and 04/22/05
A medical dispute resolution request from Dr. Frye on 05/05/05
A letter from Robert F. Josey at Harris & Harris on 08/16/05
A request for a medical dispute resolution from Mr. Josey on 08/29/05

Clinical History Summarized:

Chiropractic treatment was performed with Kayce Frye, D.C. from 01/06/05 through 03/16/05 for a total of 15 sessions. TWCC-73 forms filed by Dr. Frye on 01/07/05 and 01/26/05 noted the patient could work with restrictions. An MRI of the lumbar spine on 02/03/05 that was interpreted by James E. Remkus, M.D. revealed disc herniations at L3-L4 and L4-L5 with mild narrowing of the left neuroforamen at L3-L4 and a tear in the outer annulus with mild central canal stenosis and mild bilateral foraminal encroachment at L4-L5. A letter of medical necessity for a TENS unit by Dr. Frye was noted 03/17/05. Dr. Frye wrote a request for reconsideration of the chiropractic treatment on 04/06/05 and 04/22/05. On 05/05/05, Dr. Frye provided a request for a medical dispute resolution for chiropractic treatment. Robert F. Josey of Harris and Harris noted he was representing the insurance carrier on 08/16/05. He also wrote a letter regarding the request for a medical dispute resolution on 08/29/05 for reimbursement of physical therapy services from 01/14/05 through 07/25/05.

Disputed Services:

Therapeutic exercises, therapeutic activities, and chiropractic manipulative treatment from 02/01/05 through 03/16/05

Decision:

I agree with the requestor. The therapeutic exercises, therapeutic activities, and chiropractic manipulative treatments from 02/01/05 through 03/16/05 were reasonable and necessary.

Rationale/Basis for Decision:

The treatment provided to the patient satisfied the qualifications of Section 408.021 of the Texas Labor Code, which only substantiates the need for care, which (1) cures or relieves the effects naturally resulting from the compensable injury, (2) promotes recovery, or (3) enhances the ability of the employee to return to or retain employment. Based upon review of the medical documentation, the patient suffers from significant injury in the form of a two level lumbar disc herniation as demonstrated by MRI evaluation. Based upon the supplied documentation, including treatment from Dr. Frye's office, the patient's condition appeared to progress at a reasonable pace under the treatment plan provided by Dr. Frye. Therefore, based upon the supplied documentation, the above mentioned services provided by Dr. Frye's office between 02/01/05 and 03/16/05 do satisfy the qualifications of Section 408.021 and were, therefore, reasonable and necessary as related to the original injury.

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 Commission 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 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 09/20/05 from the office of Professional Associates.

Sincerely,

Amanda Grimes
Secretary/General Counsel