



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

<b>Type of Requestor:</b> (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier	
Requestor's Name and Address: Gabriel Gutierrez, D.C. P O BOX 229 Katy, Texas 77492-0229	MDR Tracking No.: MDR Tracking No. M5-05-3212-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Company Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: TWCC-60 package, CMS 1500s, explanations of benefits and medical documentation  
POSITION SUMMARY: The treatment provided to Mr. \_\_\_\_\_ was reasonable and medically necessary consistent with the concepts of medical necessity as per The Texas Labor Code Section 408.021(a) and applicable Guidelines.

#### PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to TWCC-60 including copy of peer review  
POSITION SUMMARY: This is a fee disputed involving retrospective medical necessity. The carrier disputes that the provider has shown that the treatment underlying the charges was medically reasonable and necessary. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made. Further, the documentation provided does not establish medical necessity.

#### PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-16-04 to 01-20-05	97110, 99212, 99211, 99215, 97032, 97140, 90801 and 97124	<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. This dispute also contained services that were not addressed by the IRO and will be reviewed by Medical Dispute Resolution.

On 09-06-05, 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 99080-73 dates of service 09-15-04 and 10-01-04 denied with denial code "V" (unnecessary medical treatment with peer review). The TWCC-73 per Rule 129.5 is a required report which is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION**

28 Texas Administrative Code Sec. 133.308, Rule 129.5

**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 \$30.00. 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. In addition, the Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee.

Findings and Decision and Order by:

10-06-05

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date of Findings and 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

Fax 512/491-5145

Phone 512/248-9020

IRO Certificate #4599

## NOTICE OF INDEPENDENT REVIEW DECISION

September 27, 2005

Re: IRO Case # M5-05-3212 -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 Workers' 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 cases be assigned to certified IROs, TWCC this case was assigned 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 Workers' 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. letter of medical necessity 9/13/05
4. Rehab program notes, Dr. Gutierrez
5. Progress notes, Dr. Gutierrez
6. Illustrated stretch exercises
7. Consulting physician reports, Dr. Donovan
8. CT scan lumbar spine report 3/24/05
9. EMG report 2/10/05
10. Progress notes, Dr. Donovan
11. Report 11/1/04, Dr. McConnell
12. Reports, Concentra medical Centers

### History

The patient injured his lower back in \_\_\_ when he bent over, grabbed, and attempted to lift an object and felt a "pop" and instant low back pain. He initially went to Concentra, and then sought chiropractic treatment.

### Requested Service(s)

Psychiatric diagnostic interview examination, therapeutic exercises, electrical stimulation, manual therapy technique, massage, office visits 9/16/04 - 1/20/05

### Decision

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

Rationale

The patient had an intensive course of conservative treatment from his D.C. with minimal relief of symptoms and minimal gains in strength and ranges of motion relative to the intensity of services. For medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. There is no indication in the notes provided for this review that the patient continued to receive any significant, lasting objective benefit from treatment. The D.C.'s notes are very generalized and lack any specific quantitative findings for pain intensity, ROMs, or strength gains to support the intensive treatment rendered. If an individual's expected restoration potential is insignificant in relation to the extent and duration of services required to achieve such potential, the services would not be reasonable and necessary. The records provided for this review do not validate functional improvement, progression of rehab program, or a move towards self-directed care.

In a 6/17/05 consult, an orthopedic surgeon recommended a lumbar hemilaminectomy with partial discectomy and decompression of the right L5 nerve root. He based his documentation on a positive MRI, weakness in the right EHL, and numbness to the right L5 nerve root. The findings indicate that the D.C.'s treatment failed. The D.C. should have realized after a couple of months of failed treatment that surgery was the only realistic option, but instead inappropriate treatment was continued

This medical necessity decision by an Independent Review Organization is deemed to be a Workers' Compensation Division decision and order.

Sincerely,

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Daniel Y. Chin, for GP