



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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Cotton D. Merritt, D.C. 2005 Broadway Lubbock, Texas 79401	MDR Tracking No.: M5-05-3337-01
	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

DWC-60 dispute package. Position summary: Per the table of disputed services "all care is reasonable and medically necessary".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Response to DWC-60 package. Position summary: Texas Mutual denied some of the charges in dispute based on local coverage determination (LCD) policy-Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries-Y-13B-R7, issued by Trailblazer, the administrator for Medicare in Texas.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-04-05 to 05-18-05	99212-25, 97110, 97140 and 97112	<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.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

PART VII: DIVISION DECISION

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 not entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

12-09-05

Authorized Signature

Date of Findings and Decision

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

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 14, 2005

Re: IRO Case # M5-05-3337 –01

Texas Department of Insurance, Division of Workers' Compensation:

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 Division of 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, 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 physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for the Division of 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 the injured employee, the injured employee's employer, the carrier, the utilization review agent, 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. MRI lumbar spine report 6/4/04
4. Evaluation 6/24/04, Dr. Merritt
5. Medical records, follow up notes, Dr. Merritt 2004-2005
6. Operative report 1/28/05, Dr. LeGrand
7. Carrier statement 10/4/05
8. Follow up notes with x-ray reports 2005, Dr. LeGrand
9. X-ray report lumbar spine 7/7/05, 5/19/04
10. History & Physical 2/8/05, and Hospital discharge summary 2/12/05, Dr. LeGrand
11. Discharge summary 1/30/05, Dr. LeGrand
12. Report lumbar myelogram 12/28/04
13. CT lumbar spine report 12/28/04
14. Initial office evaluation 12/20/04, Dr. LeGrand
15. Letter of medical necessity 9/26/05, Dr. Merritt
16. Impairment rating 7/6/05, Dr. Merritt
17. Electrodiagnostic evaluation, Dr. Merritt
18. Evaluation 7/15/04, follow up note 8/19/04, Dr. Dewitt

History

The patient injured his low back in ___ after lifting a water pump into a pick up truck. He reported acute, sharp pain in his low back. He was initially treated at a medical center. X-rays were taken that revealed degenerative changes. A 6/4/04 MRI indicated a broad-based disk bulge and mild herniation at L2-3, right central herniation at L3-4, central left broad-based herniation at L4-5, mild disk bulge at L5-S1. The patient changes his treating doctor, and began with his treating D.C. on 6/28/04. He was treated extensively by his D.C. for three months. He was also treated by a pain management specialist. The patient was referred for neurosurgical evaluation on 12/20/04. A CT scan of the lumbar spine revealed multilevel spondylosis and and degenerative disk disease L2 - L5-S1, with bilateral pars defects at L5-S1. There was also spinal stenosis at L2-3 and L3-4. Lumbar myelography revealed thecal sac deformity L2 – L5-S1, with bilateral nerve root sleeve cut off at L3-4, greater on the left, and spinal stenosis L2-3 and L3-4. Surgery was recommended, and performed on 1/28/05, including L2-S1 laminectomies, decompression L2-S1 bilaterally and a two-level fusion at L4-5 and L5-S1. Post operatively, the patient developed some leg pain, for which he was admitted to the hospital and given a lumbar injection with Depo-Medrol and Marcaine. The injection relieved his leg pain. The patient resumed treatment with his D.C. on 3/2/05, and started post-surgical physical therapy on 3/4/05. He continued with physical therapy through 5/18/05. On 7/6/06 the treating D.C. certified that the patient was at MMI, and assigned him a 20% whole person impairment.

Requested Service(s)

Office visits, therapeutic exercises, manual therapy technique, neuromuscular reeducation 3/4/05 – 5/18/05

Decision

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

Rationale

The patient underwent surgery to the lumbar spine and appropriately began post-surgical physical therapy, lasting for more than ten weeks. Guidelines recommend physical therapy three times per week on non-consecutive days for up to 45 minutes per session. The carrier has already reimbursed the D.C. for three, 50-minute- units of physical therapy per week during the period in dispute. The documentation provided for this review does not support the need for therapy beyond the current recommended guidelines of 45 minutes per session. Services beyond this would not be medically necessary. Furthermore, separate evaluation and management services are not necessary at the time of physical therapy.

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

Sincerely,

Daniel Y. Chin, for GP