



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:	MDR Tracking No.: M5-06-0076-01
Bratcher Injury and Wellness Center, P.A. 225 E. Amherst Dr., Ste C Tyler, TX 75701	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: City of Tyler, Box 11	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "The doctor thought it was necessary for her to have 12 visits within 6 weeks. It is documented that the patient was not at MMI by two different doctors appointed by DWC who recommended that she continue with her care. She also continued to perform at work throughout her injury."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The services in question were denied based on peer review opinion."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
1-10-05 – 5-26-05	CPT codes 99213, G0283, 97110, 98940, 98943, 97140-GP-59, 97024	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0

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 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 9-29-05 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.

The requestor did not submit a copy of the medical bills per Rule 133.307 (e)(2)(A) which states, “ a copy of the medical bills as originally submitted to the carrier for reconsideration in accordance with 133.304.” must be submitted to the Division.

Per the Table of Disputed Services the requestor completed forty-eight DWC-73 reports between dates of service 1-10-05 and 5-26-05. The insurance carrier denied this service for “M-No maximum allowable reimbursement”, “309-The charge for this service exceeds the fee schedule allowance”, “269-This billing is for a service unrelated to the work illness or injury,” “203-medical necessity” or for “150-payment adjusted because the payer deems the information submitted does not support this level of service.” The insurance carrier did not submit a DWC-21 documenting the reasons this service is “unrelated to the work illness or injury”. Rule 129.5(d)(3) states that the employer may request the DWC-73 report on a schedule “not to exceed one report every two weeks.” The requestor submitted the required documentation to support a change in the injured worker’s condition and, therefore, the need for the DWC-73 for five of the reports listed on the Table of Disputed Services. Recommend reimbursement of \$75.00 for the reports on 1-12-05, 1-27-05, 2-24-05, 4-5-05 and 5-9-05.

CPT code 98940 on 4-18-05 was denied by the carrier as “M-No maximum allowable reimbursement” and as “269-This billing is for a service unrelated to the work illness or injury.” DWC Rules do have a MAR for this CPT code. The insurance carrier did not submit a DWC-21. The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement recommended.

CPT code G0283 on 4-18-05 was denied by the carrier as “M-No maximum allowable reimbursement” and as “269-This billing is for a service unrelated to the work illness or injury.” DWC Rules do have a MAR for this CPT code. The insurance carrier did not submit a DWC-21 documenting the reasons this service is “unrelated to the work illness or injury”. The IRO states that this service is not medically necessary and the IRO decision is a Division decision. No reimbursement recommended.

CPT code 97110 on 4-18-05 and 4-20-05 was denied by the carrier as “M-No maximum allowable reimbursement” as “D-duplicate bill” and as 269-This billing is for a service unrelated to the work illness or injury.” DWC Rules do have a MAR for this CPT code. The insurance did not submit a DWC-21. Per the 2002 MFG this service is not a component of another performed on this date. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. No reimbursement recommended.

CPT code 98940 on 4-20-05 was denied by the carrier as “1014-We find our original review to be correct, therefore, no additional allowance appears to be warranted.” Neither the carrier nor the requestor provided original EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s per rule 133.307(e)(3)(B). The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement recommended.

CPT code G0283 on 4-20-05 was denied by the carrier as “1014-We find our original review to be correct, therefore, no additional allowance appears to be warranted.” Neither the carrier nor the requestor provided original EOB’s. The requestor submitted convincing evidence of carrier receipt of provider’s request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB’s per rule 133.307(e)(3)(B). The requestor did not provide documentation to support delivery of services per Rule 133.307(g)(3)(A-F). No reimbursement recommended.

CPT code 97110 on 5-9-05 and 5-11-05 was denied by the carrier as “F-Fee Guideline MAR Reduction” and as “D-Duplicate Bill” and “306-Billing is duplicative of other services performed on same day.” Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting

that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. No reimbursement recommended.

CPT code 97110 on 4-28-05 was denied by the carrier as "1014-We find our original review to be correct, therefore, no additional allowance appears to be warranted." Neither the carrier nor the requestor provided original EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307(e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Division has reviewed the matters in light all of the requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. No reimbursement recommended.

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PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 129.5(d)(3), 133.307, 133.308 and 134.202(c)(1).

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 a refund of the paid IRO fee. The Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute in the amount of \$75.00. 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.

Findings and Decision and Order by:

Donna Auby

1-17-06

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 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.



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M5-06-0076-01
NAME OF REQUESTOR: Bratcher Injury & Wellness Center, P.A.
NAME OF PROVIDER: Luther Bratcher, D.C.
REVIEWED BY: Licensed by the Texas State Board of Chiropractic Examiners
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 11/02/05

Dear Bratcher Injury & Wellness Center, P.A.:

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 License in the area of Chiropractics and is currently listed on the DWC 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 the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An Employer's First Report of Injury or Illness dated 10/19/04
An initial evaluation with Luther Bratcher, M.Ed., D.C., dated 10/22/04
Chiropractic treatment notes from Dr. Bratcher dated 11/02/04, 11/03/04, 11/04/04, 11/05/04, 11/06/04, 11/08/04, 11/10/04, 11/12/04, 11/15/04, 11/17/04, 11/18/04, 11/22/04, 11/24/04, 11/26/04, 11/29/04, 12/01/04, 12/02/04, 12/03/04, 12/06/04, 12/08/04, 12/09/04, 12/13/04, 12/15/04, 12/16/04, 12/20/04, 12/22/04, 12/23/04, 12/24/04, 12/27/04, 12/29/04, 12/30/04, 01/03/05, 01/05/05, 01/06/05, 01/10/05, 01/12/05, 01/13/05, 01/17/05, 01/19/05, 01/20/05, 01/24/05, 01/27/05, 01/31/05, 02/03/05, 02/07/05, 02/09/05, 02/10/05, 02/14/05, 02/16/05, 02/18/05, 02/22/05, 02/23/05, 02/24/05, 03/02/05, 03/03/05, 03/07/05, 03/09/05, 03/10/05, 03/11/05, 03/14/05, 03/16/05, 03/18/05, 03/23/05, 03/24/05, 03/28/05, 03/30/05, 03/31/05, 04/05/05, 04/06/05, 04/07/05, 04/11/05, 04/13/05, 04/18/05, 04/20/05, 04/25/05, 04/28/05, 05/02/05, 05/04/05, 05/09/05, 05/11/05, 05/18/05, 05/19/05, 05/23/05, 05/26/05, 06/01/05, 06/02/05, 06/06/05, 06/08/05, 06/15/05, 06/16/05, 06/20/05, and 06/23/05

An initial evaluation with R.W. Rodgers, D.O. dated 11/04/04
An MRI of the lumbosacral spine dated 11/16/04 and signed by Ralph Gutierrez, M.D.
An MRI of the left leg obtained on 11/16/04 and interpreted by Dr. Gutierrez
Review of the MRI dated 11/16/04 by Dr. Bratcher
An EMG/NCV study of the bilateral lower extremities dated 11/16/04 and interpreted by Russell Packard, M.D.
An ultrasound study of the soft tissues of the spine dated 11/16/04 and interpreted by Zirojin Parlovic, M.D.
Another evaluation with Dr. Rodgers dated 11/18/04
A follow-up evaluation dated 11/22/04 from Dr. Bratcher
Physical therapy notes from an unknown provider (the signature was illegible) on 11/22/04, 11/23/04, 11/24/04, 11/29/04, 12/01/04, 12/02/04, 12/06/04, 12/08/04, 12/09/04, 12/13/04, 12/15/04, 12/16/04, 12/20/04, 12/22/04, 12/23/04, 12/27/04, 12/29/04, 12/30/04, 01/03/05, 01/05/05, 01/06/05, 01/10/05, 01/12/05, 01/13/05, 01/17/05, 01/19/05, 01/20/05, 01/24/05, 01/25/05, 01/27/05, 01/31/05, 02/02/05, 02/03/05, 02/07/05, 02/09/05, 02/10/05, 02/14/05, 02/15/05, 02/18/05, 02/22/05, 02/23/05, 02/29/05, 03/07/05, 03/09/05, 03/10/05, 03/14/05, 03/16/05, 03/18/05, 03/23/05, 03/24/05, 03/28/05, 03/30/05, 03/31/05, 04/05/05, 04/06/05, 04/07/05, 04/11/05, 04/13/05, 04/18/05, 04/20/05, 04/25/05, 04/27/05, 04/28/05, 05/02/05, 05/04/05, 05/05/05, 05/09/05, 05/11/05, 05/18/05, 05/19/05, 05/23/05, 05/26/05, 06/01/05, 06/02/05, 06/06/05, 06/08/05, 06/15/05, 06/16/05, 06/20/05, 06/23/05, 06/24/05, and 07/06/05
Another evaluation with Dr. Rodgers dated 12/02/04
A follow-up evaluation with Dr. Bratcher dated 12/24/04
Additional follow-up notes from Dr. Rodgers dated 12/30/04, 01/20/05, 02/03/05, and 03/03/05
A letter written by Dr. Bratcher dated 01/25/05
A Designated Doctor Evaluation dated 01/25/05 from Ricky McShane, D.O.
A TWCC-69 form dated 01/25/05 and signed by Dr. McShane
An amended letter dated 02/25/05 from Dr. McShane
A letter addressed by Dr. Bratcher dated 03/03/05
A letter to Dr. Larry Isbell (credentials were not provided) from Dr. Bratcher dated 05/06/05
A TWCC-73 form signed by Chet Nix, D.C. dated 07/06/05
A Functional Capacity Evaluation (FCE) dated 07/11/05 from Dr. Nix
An impairment rating performed on 07/13/05 by Dr. Bratcher
A TWCC-69 form signed by Dr. Bratcher on 07/13/05
A TWCC-73 form signed by Dr. Bratcher on 07/13/05
A letter "To Whom It May Concern" dated 07/20/05 from Dr. Nix.
A Designated Doctor Evaluation with Howard Hood, M.D. dated 08/17/05
Another letter addressed to Professional Associates dated 09/30/05 and signed by Linda Madsen from Claims Administrative Services, Inc.
A letter addressed to Professional Associates dated 10/03/05 from Dr. Bratcher

Clinical History Summarized:

The Employer's First Report of Injury or Illness stated the patient went to the back of a book mobile to watch while the driver was backing. As the driver pulled forward, it caused the patient to lose her balance on _____. On 10/19/04, Dr. Bratcher prescribed ultrasound, electrical stimulation, therapeutic exercises, and spinal manipulation three times a week for one month. On 11/02/04 through 06/23/05, the patient attended chiropractic therapy with Dr. Bratcher. An MRI of the lumbar spine on 11/16/04 revealed mild disc desiccation at multiple disc levels and at L3-L4, there was a moderate sized left paracentral disc extrusion with disc material extending into the upper left L4 lateral recess that indented the dural sac. An EMG/NCV study of the bilateral lower extremities on 11/16/04 showed evidence for a peripheral neuropathy, primarily motor. From 11/22/04 through 06/24/05, the patient attended chiropractic therapy with the unknown provider. On 01/20/05, Dr. Rodgers recommended continued rehabilitation, as well as continued light limited duty. On 01/25/05, Dr. McShane performed a Designated Doctor Evaluation and felt the patient had not reached Maximum Medical Improvement (MMI), but would on or about 07/25/05. Dr. Nix performed an FCE on 07/11/05 and the patient demonstrated the ability to perform at the light physical demand level, which was the required physical demand level for her job. On 07/13/05, Dr. Bratcher performed an impairment rating and placed the patient at MMI as of 07/13/05 and assigned her a 0% whole person impairment rating. Dr. Hood performed a Designated Doctor Evaluation on 08/17/05 and placed the patient at MMI on 08/17/05 with a 5% impairment rating. In a letter to Professional Associates dated 09/30/05, Ms. Madsen noted the patient attended chiropractic care with Dr. Bratcher for 12 weeks for approximately 35 visits. On 10/03/05, Dr. Bratcher addressed a letter to Professional Associates providing a brief case summary on the patient. He noted that since the doctors

who were appointed by the Texas Workers' Compensation Commission (TWCC) to examine the patient all recommended she continue her chiropractic care and active therapy, she was not at MMI. Dr. Bratcher felt the immediate past care was warranted and should not have been denied.

Disputed Services:

Electrical stimulation, therapeutic exercises, chiropractic manipulative treatment, manual therapy technique, and diathermy from 01/10/05 through 05/26/05

Decision:

I disagree with the requestor. The electrical stimulation, therapeutic exercises, chiropractic manipulative treatment, manual therapy technique, and diathermy from 01/10/05 through 05/26/05 were neither reasonable nor necessary.

Rationale/Basis for Decision:

Based upon review of the records provided, in my opinion, the documentation did not support that the treatment with electrical stimulation, therapeutic exercises, chiropractic manipulative treatment, manual therapy technique, and diathermy of 01/10/05 through 05/26/05 were reasonable and medically necessary as related to the injury of _____. The records indicated the patient was treated over a 12-week period from 10/22/04 through 01/06/05 for a total of approximately 35 visits, which were considered by the carrier. The patient continued to receive passive and active therapy from 01/10/05 through 05/26/05, which was an additional 20-week period of an additional 50 visits. Continued treatment with passive modalities and therapeutic exercises in the office setting would not be considered reasonable or medically indicated. Based upon guidelines set forth in Chapter 3, Chapter 8, and Chapter 12 of the *ACOEM Guidelines*, which pertain to the initial approach to treatment, treatment of neck and upper back complaints, and treatment of low back complaints, it was noted that specific recommendations are made on the use of both manipulative and physical medicine modalities. On page 48, it was noted that from the acute to subacute phases, for a period of two weeks or less, physicians could use passive modalities such as the application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. Although not for long-term use, transcutaneous galvanic and electrical stimulation could keep symptoms at bay temporarily, diminishing pain long enough so the patient begins to mobilize. Little evidence suggested the effectiveness of other passive modalities. It continues by stating that manipulative therapy on appropriately selected patients may be effective in aiding recovery as opposed to promoting or providing merely short-term comfort, only in patients with low back pain for defined periods of time (less than four weeks duration). There was some controversy regarding the use of spinal manipulation on patients with radiculopathy. On Page 173, it was stated that there was no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities, such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neural stimulation (TENS) unit, and biofeedback. Finally, on Page 298 to 299, it stated that manipulation appeared safe and effective in the first few weeks of back pain, without radiculopathy. Nonetheless, in the acute phases of injury, manipulation may enhance the patient's mobilization. If manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. In a patient with symptoms lasting longer than one month, manipulation was probably safe, but efficacy has not been proved.

Finally, in regard to physical modalities, it also stated that insufficient scientific testing exists to determine the effectiveness of those therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Records clearly indicated that this patient was treated with both passive and active modalities for a sufficient period of time, which was 12 weeks, for a total of approximately 35 visits. Treatment beyond that timeframe with the same form of physical intervention would require appropriate and substantial documentation to support the medical necessity. In reviewing the daily progress notes that have been submitted, to include the daily notes and the physical therapy notes, it was noted that those records were not maintained in a commonly accepted medical/chiropractic format and do not set forth the subjective complaints, objective findings, assessment, and plan or prognosis in a descriptive or narrative format. The form of record keeping utilized does not conform to the generally accepted standard of care for documentation of daily patient encounters and does not support the medical necessity of all of the services provided and frequency of care, or length of care. In regard to the physical medicine modalities and procedures utilized to include the ultrasound treatment, cold laser therapy, joint mobilization, diathermy, therapeutic exercises, and therapeutic activities. It was specifically noted that there was no documentation indicating the area being treated, the length of time for each treatment, the settings or frequency utilized in the treatment, who actually performed the treatment, and what was the patient's response to the treatment. In accordance with Texas Administrative Code, Title 28, Part II, Chapter 133, Subchapter A, Rule 133.1, it would be the responsibility of the healthcare provider to submit progress or SOAP notes substantiating the care and need for further treatment and services, and indicating progress, improvement, the date of the next treatment, and services, complications, and expected release date. Treatment notes provided for review did not substantiate why those services were being provided to the employee after the initial allowance of 35 visits over a 12 week period. The medical records did not provide clinical documentation to support the medical necessity of the procedures utilized.

In closing, it appeared the treatment provided from 01/10/05 through 05/26/05 lacked sufficient documentation to support that the care provided was reasonable and medically necessary. It appeared that all treatment beyond that timeframe would be considered excessive.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

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 are 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 11/02/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel