



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address:	MDR Tracking No.: M5-06-0170-01
Allen Glen Haywood, D. C. P.O. Box 242 Mabank, TX 75147	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:
Commerce and Industry Insurance, Box 19	

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include DWC-60 form, Explanations of Benefits, medical documentation and CMS 1500's. Position summary states, "Currently the doctor is providing very conservative treatment to relieve the patient's pain levels, restricted range of motion, and muscle spasms caused by her injury. The patient is entitled to healthcare as and when needed. She is specifically entitled to healthcare that relieves or cures the effects of the compensable injury and promotes recovery."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position summary states, "The carrier's basis is lack of medical necessity."

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)
11-10-04	CPT code 99212	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	0
9-15-04 – 11-15-04	CPT codes 99212 (except 11-10-04), 97012, 98940, G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$137.48

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 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 entitled to a refund of the IRO fee (\$460.00). The requestor is entitled to reimbursement in the amount of \$137.48. 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 by:

Donna Auby

12-7-05

Authorized Signature

Typed Name

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.



Specialty Independent Review Organization, Inc.

Amended 11/15/2005

November 1, 2005

DWC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
DWC #:
MDR Tracking #: M5-06-0170-01
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Division of Workers' Compensation has assigned this case to Specialty IRO for independent review in accordance with DWC Rule 133.308, which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The reviewer is on the DWC ADL. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

According to the records received, Ms. ___ was injured in a work related incident on ____. The patient was working for Security Associates when she was injured. Ms. ___ underwent lumbar surgery for her condition but continues to have symptoms related to her back. She has been subsequently diagnosed with failed back surgery syndrome and continues to receive care for her injuries.

RECORDS REVIEWED

Medical Dispute Resolution paperwork
Various EOB's
Letter from Flahive, Ogden & Latson
Peer Review by Dr. Mitchell dated 3-16-2004
Letters from Physicians Choice
Records from Dr. Haygood
TWCC Interlocutory Order

DISPUTED SERVICES

Disputed services include 99212 office visits, mechanical traction 97012, chiropractic manipulative treatments 98940 and electrical stimulation G0283 from 9-15-2004, 11-10-2004 and 11-15-2004.

DECISION

The reviewer agrees with the previous adverse decision regarding 99212 for date of service 11-10-2004.

The reviewer disagrees with the previous adverse decision regarding all other services for all dates of service under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor and Evidence Based Medicine Guidelines. The Medicare guidelines and payment policies were also utilized in the decision making process of this review. The office visit on 11-10-2004 is not considered necessary because the documentation does not support the need of the office visits in conjunction with the manipulation. The other services are necessary due to the fact that the patient has suffered from a failed back surgery and will need periodic care for flare-ups and exacerbations of her condition. Dr. Bratcher in examining the patient in February 2005 as a PRME also felt that Ms. ___ needed additional care for her condition. Failed back surgery syndrome is a very difficult condition to treat or manage according to the literature.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that the reviewing provider has no known conflicts of interest between that provider and 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 IRO.

Sincerely,

Wendy Perelli, CEO

CC: Specialty IRO Medical Director

Your Right To Appeal

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.

Sincerely,

Wendy Perelli, CEO

I hereby certify, in accordance with DWC- Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the via facsimile, U.S. Postal Service or both on this 15th day of November 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli