



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: David M. Griffith, D.C. 30525 Quinn Road # A Tomball, Texas 77375	MDR Tracking No.: M5-06-0455-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Box 01	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package

POSITION SUMMARY: Per the table of disputed services "His treatment has been reasonable, necessary and effective in reducing the pts pain level".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "The Carrier respectfully requests the Division appoint an Independent Review Organization to review the medical necessity of the services at issue in accordance with the Act and Rules".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
10-26-04 to 01-21-05	99212 (\$44.16 X 12 DOS) = \$529.92	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$7,727.58
	99212 (\$45.26 X 3 DOS) = \$135.78		
	99213 (\$61.98 X 4 DOS) = \$247.92		
	99213 (\$61.89 X 2 DOS) = \$123.96		
	97110 (5 units @ \$172.30 X 20 DOS) = \$3,446.00		
	97110 (5 units @ \$167.80 X 8 DOS) = \$1,342.40		
	97112 (1 unit @ \$34.30 X 20 DOS) = \$686.00		
	97112 (1 unit @ \$35.21 X 8 DOS) = \$281.68		
	97140 (1 unit @ \$31.73 X 20 DOS) = \$634.60		
	97140 (1 unit @ \$31.79 X 8 DOS) = \$254.32		
	99080-73 (\$15.00 X 3 DOS) = \$45.00		

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 **prevailed** on the disputed medical necessity issues.

Dates of service 10-15-04 through 10-22-04 per Rule 133.308(e)(1) were not timely filed and will not be a part of the review.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 133.308(e)(1)

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 \$7,727.58. 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.

Findings and Decision by:

01-19-06

Date of Findings and Decision

Order by:

01-19-06

Authorized Signature

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.

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

January 17, 2006

Re: IRO Case # M5-06-0455 -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 Doctor of Chiropractic, who is licensed in Texas, 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 insurance 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. TWCC 69 reports
4. Report 2/22/05, Dr. Culver
5. Letters of medical necessity 3/10/04, 10/10/04, Dr. Griffith
6. Letter to IRO 12/12/05
7. Initial report 8/16/04, Interim reports, Dr. Griffith
8. Treatment notes, Daily progress notes, Dr. Griffith
9. TWCC work status reports
10. MRI lumbar spine report 3/17/04
11. Report 8/24/04, Dr. Troyer.
12. Electrodiagnostic test report 8/27/04
13. Report 10/8/04, Dr. K.
14. FCE/PPE report 1/13/05
15. Work hardening assessment report 1/14/05
16. Report 3/25/04, Dr. A.
17. Report 8/2/04, Dr. N.

18. Pain management follow up reports, Dr. Troyer
19. PT notes, NASH Rehab Center
20. Lumbar spine rehab log, Dr. Griffith

History

The patient injured his lower back in _____. He had a course of physical therapy for several weeks with poor results. The patient then saw his now treating D.C. on 8/16/04 for chiropractic treatment and a therapeutic exercise program. An MRI and electrodiagnostic study were performed. The patient was also treated with medication and three epidural steroid injections on 10/8/04, 11/10/04 and 12/27/04. The patient underwent post-injection rehab with his D.C. after each injection.

Requested Service(s)

Office visits, therapeutic exercises, neuromuscular re-education, manual therapy techniques, DWC required report. 10/26/04 – 1/21/05.

Decision

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

Rationale

The patient had an initial trial of physical therapy prior to starting treatment with his D.C., and that trial had failed to relieve pain or improve function, and failed to return the patient to work. The physical therapy at issue in this dispute was performed concurrently with a series of epidural steroid injections. With the post-injection rehab, the patient's VAS decreased from 10/10 to 0-1/10. The treatment may have exceeded general guidelines for post-injection therapy, but the D.C.'s documentation supported continued treatment as the patient's pain decreased and function improved with each ESI and post-injection follow-up phase of therapy. The D.C. properly documented improved function, ROM and a progression to a more active treatment protocol, which included pelvic stabilization, active ROM, core stabilization, and McKenzie-type protocol. He utilized Cybex and progressive resistance training to improve strength. Endurance training and cardiovascular exercise also produced favorable results.

The active physical therapy protocols were well-documented, and the treatment plan and rationale were also adequately noted. The patient was able to return to work without restriction, and follow up evaluation showed the patient to be doing very well, without exacerbation, and without further treatment.

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

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 a 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 the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

Daniel Y. Chin, for GP