



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	
Requestors Name and Address: Laurence N. Smith, D.C. P O BOX 551413 Dallas, Texas 75355-1413	MDR Tracking No.: M5-06-0481-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Zurich Insurance Company Rep Box # 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

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

DOCUMENTATION SUBMITTED: DWC-60 dispute

POSITION SUMMARY: "I believe this is a simple and straight forward error by the carrier. The carrier originally denied the claim as being uncompensable. After several months went by the CCH was held and the hearing office state, in February 2005 (see attached) that the injury was compensable, their was disability and all parties should be reimbursed. The carrier never paid for dates of service after the CCH decision up to the point of surgery but never paid for the dates of service when Mr. \_\_\_ was first seen, leading up to the CCH decision. This may have been an oversight but our office is still entitled to reimbursement for services rendered plus interest via the citation cited below".

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

DOCUMENTATION SUBMITTED: Response to DWC-60

POSITION SUMMARY: "Attached is the completed TWCC-60 and EOBs. Carrier will respond with addition documentation upon appointment of the IRO".

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-01-04 to 12-01-04	99205 (1 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$221.84
	97032 (1 unit @ \$20.20 X 12 DOS)		\$242.40
	99213 (\$68.24 X 11 DOS)		\$750.64
	97024 (1 unit @ \$7.76 X 8 DOS)		\$62.08
<b>TOTAL</b>			<b>\$1,276.96</b>

#### 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 **majority** of 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 03-31-06, 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.

Dates of service 03-07-05 through 05-27-05 were indicated to have been paid by the carrier on the table of disputed services submitted. Confirmation of receipt of payment was made with the Requestor, therefore these dates of service will not be a part of the review.

CPT code 97024 dates of service 02-07-05, 02-11-05, 02-14-05 and 02-15-05 were denied by the carrier with denial code "M:Z8" (A procedure has been billed on the same date, and on the same site, as a more extensive procedure. Since the extensive procedure has an increased level of complexity, a charge for the less extensive procedure is not appropriate). Per the 2002 Medical Fee Guideline code 97024 is not global to other services billed on the dates of service in dispute. Reimbursement recommended in the amount of **\$31.04 (\$7.76 X 4 DOS)**.

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

28 Texas Administrative Code Sec. 133.308 and 134.202

#### **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 \$1,308.00. The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. 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.

**Ordered by:**

05-05-06

\_\_\_\_\_  
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

April 26, 2006

Re: IRO Case # M5-06-0481 -01 \_\_\_ amended 5/2/06

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. IME 1/3/05, Dr. Xeller
4. Medicare reports – E&M documentation
5. TWCC subchapter A,B
6. MDR & IRO report 10/26/05
7. Records, treatment notes, rehab notes, Cornerstone Clinics
8. MRI left knee report 2/29/04

### History

The patient injured his left knee in \_\_\_ when he pushed in the clutch of his truck and felt pain. He has been treated with medication and chiropractic treatment.

### Requested Service(s)

Electrical stimulation, office visits, ultrasound, manual therapy technique, diathermy, mechanical traction, therapeutic exercises  
11/1/04 – 2/28/05.

### Decision

I disagree with the carrier's decision to deny the requested services 11/1/04 through 12/1/04, except for manual therapy technique (97140-59), and I agree with the decision to deny all manual therapy technique services, and all treatment after 12/1/04.

### Rationale

The patient deserved a trial of conservative treatment. However, the documentation provided for this review fails to show any significant relief of symptoms or improved function. An orthopedic surgeon evaluated the patient on 1/3/05, and noted that the patient still had sharp, stabbing, cramping, throbbing and burning of moderate intensity, and also numbness and tingling in the left knee. It was also noted that the patient said that the pain was getting worse.

The D.C.'s documentation was repetitive on a day-to-day basis, lacked objective findings such as orthopedic tests, and palpatory and visual findings. The patient's condition never changed, and the plan of treatment never changed.

Twelve visits would be a reasonable and necessary, fair trial of conservative treatment, even though treatment failed. It appears from the records that the D.C. did everything he could to help the patient. The D.C. tried to get the patient to an orthopedic specialist earlier in the treatment phase, but that was denied by the carrier, as was an MRI.

Although treatment was warranted for the period 11/1/04 – 12/1/04, the documentation provided does not support use of 97140-59 during that period. Treatment after 12/1/04 failed to cure or relieve the effects of the injury, failed to promote recovery, and failed to enhance the ability of the patient to work.

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,

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Daniel Y. Chin, for GP