



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: Summit Rehabilitation Centers 2500 West Freeway # 200 Fort Worth, Texas 76102	MDR Tracking No.: M5-06-0633-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Casualty company Box 47	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 MFG, Reimbursement for services is dependent on the accuracy of the coding and documentation. All participants shall be responsible for correctly applying the ground rules contained within the Medical Fee Guideline, and the rules contained within the CPT/HCPCS, the ICD-9-CM coding system, and the global service surgery coding guidelines..."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 response
 POSITION SUMMARY: "Carrier, American Casualty Company, respectfully submits its DWC-60 response with supporting documentation. The Healthcare Provider must bill for and provide services in a manner that is consistent with the NCCI edits".

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-22-05 to 4-3-05	95833 (global to 99213 billed on DOS disputed) 95851 (global to 95833 billed on DOS disputed) 99213 (global to 98940 billed on DOS disputed) 96004 (payment of \$120.84 made, MAR \$155.25) NOTE: Per Rule 133.308(p)(5) an IRO decision is deemed to be a Division decision and order	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$34.41
4-4-05 to 4-21-05	95851, 96004, 97012, 97110, 97140, G0283, 97140-59, 98940, 99213, 95833, 97116 and 99080-73	<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 **prevailed** 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 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 additional reimbursement in the amount of \$34.41. 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.

Ordered by:

02-10-06

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

Fax 512/491-5145

Phone

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 17, 2006

Re: IRO Case # M5-06-0633 -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. Doctor's position statement 12/20/05
4. Reports 3/05 -4/05, Dr. Small
5. Report 3/3/05, Dr. C.
6. MRI lumbar spine report 4/6/05
7. D.D. report 4/19/05, Dr. Kern
8. TWCC 69 reports
9. SOAP notes, Dr. Subia
10. D.D. evaluation 6/3/05, Dr. Shropolos
11. FCE report 2/22/05
12. Behavioral consultation report 4/18/05
13. TWCC work status reports
14. SOAP notes
15. Radiology report 5/5/05
16. Spinal ultrasound report 6/2/05
17. Electrodiagnostic test report 6/2/05
18. Treatment notes

History

The patient injured his lower back, middle back and neck in ___ when he was hit from behind by a forklift. He initially saw a company doctor, and then sought the care of his now treating D.C. for chiropractic care on 2/22/05. Spinal ultrasound, MRI of the lumbar spine, and electrodiagnostic testing have been performed. The patient has been treated with medication and physical therapy.

Requested Service(s)

Office visits, therapeutic exercises, ROM measurements, mechanical traction, manual therapy technique, electrical stimulation, chiropractic manipulative treatment, muscle testing-whole body, gait training, special reports, physician review/interpretation of comprehensive computer-based motion analysis with written report. 2/22/05 4/21/05.

Decision

I disagree with the carrier's decision to deny the requested services 2/22/05 – 4/3/05, and I agree with the denial of services 4/4/05 – 4/21/05.

Rationale

The patient was deserving of an initial trial of conservative treatment following his injury. However, treatment must be reasonable and necessary in relieving pain and/or improving function in order for treatment to continue.

Based on the documentation presented, the D.C.'s treatment failed to be of any significant benefit to the patient. The records provided for review failed to show any subjective relief of pain during the treatment period in this dispute. The patient's VAS ranged from 7 – 10 on a scale of 0 – 10. In the D.D. report of 6/3/05, it was noted that the patient's VAS was still as high as 8, after some 3 ½ months of extensive chiropractic treatment at a frequency of 3-4 times per week.

A 4/19/05 report of a FCE noted a VAS of 9/10, inconsistent effort, positive Waddell signs, submaximal effort, exaggerated pain levels, and overall poor effort secondary to increased pain levels, indicating a myriad of problems. The patient was also depressed, unable to sleep, and failed to respond to medication for pain.

Based on the records provided for this review, it is doubtful that the patient would have responded favorably to any form of conservative treatment, and he should have been referred to a pain specialist for further evaluation.

The D.C.'s documentation was voluminous, repetitive, and lacked specific objective findings, such as ROM, strength gains, and functional improvement. The documentation did not show that treatment was of benefit or that supported its continuation. The continued use of failed conservative treatment does not establish a medical rationale for further ineffective treatment. The patient had an adequate trial of conservative treatment from 2/22/05 – 4/3/05 that failed to be of significant benefit. Therefore, treatment after 4/3/05 was not reasonable and necessary.

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