



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: SCD Back and Joint Clinic, Ltd 200 E. 24 th Street, Suite B Bryan, Texas 77803	MDR Tracking No.: M5-06-0839-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Box 28	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: "It is our position that these services were reasonable, necessary, and related to the compensable injury."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: None submitted by Respondent

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
12-29-04 to 01-07-05	97018 (\$7.51 X 5 DOS = \$37.55) G0283 (\$13.61 X 5 DOS = \$68.05) 97530 (\$68.60 X 5 DOS = \$343.00) 97530 (\$102.90 X 2 DOS = \$205.80) 97112 (\$137.20 X 1 DOS = \$137.20) 97112 (\$68.60 X 3 DOS = \$205.80) 97112 (\$102.90 X 3 DOS = \$308.70) 98943 (\$27.97 X 7 DOS = \$195.79) 99211-25 (\$23.35 X 4 DOS = \$93.40) 97124 (\$25.69 X 2 DOS = \$51.38) 99212 (\$41.91 X 1 DOS = \$41.91)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$1,688.58
01-10-05 to 08-19-05	99211-25, 97018, G0283, 97530, 97112, 98943, 97124, 99212-25, 99080-73, 99213, 99211, A9150, A4595, 73110-WP, 99212 and 97026	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
		TOTAL	\$1,688.58

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 the disputed medical necessity issues.

The Requestor submitted an updated table on 03-08-06, which is used for the review.

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 03-01-06, 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.

CPT code 99455-V3-WP date of service 07-29-05 listed on the table of disputed services by the requestor was paid in the amount of \$191.21 with check number 11942551. The Respondent's explanation of benefits did not provide a denial code. Additional reimbursement is recommended in the amount of **\$108.79**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(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 \$1,797.37. 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:

03-16-06

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

February 23, 2006

Re: IRO Case # M5-06-0839 –01 ___ amended 2/27/06

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. Case summary 2/2/06, Dr. Bailey
4. Work status reports
5. Initial exam report 12/8/04, Dr. Wyatt
6. Change of treating doctors 12/8/04
7. Narrative report 1/18/05, 3/4/05, Dr. Wyatt
8. IT report 7/29/05, Dr. Wyatt
9. Exercise grid charts, Dr. Wyatt
10. SOAP notes, Dr. Wyatt
11. Review 7/8/05, 2/9/05, Dr. Soto
12. Review 2/11/04, Dr. Dodge
13. First report of injury
14. RME report 5/7/04, Dr. Ratliff
15. RME report 7/26/05, Dr. Stuck
16. IRO submission appendix A
17. Electrodiagnostic report 7/13/04
18. Progress notes, Dr. Shanti
19. Notes, Dr. Suchowicki
20. ER reports

21. Operative and follow up reports, Dr. Berliner
22. Physical therapy notes, Burleson County PT
23. Description of DMEs

History

The patient injured both wrists in ___ when he was thrown from a machine that he was driving. He underwent surgery on the left wrist on 9/10/03. He initiated chiropractic treatment with his treating D.C. on 12/8/04.

Requested Service(s)

Paraffin bath, electrical stimulation, therapeutic activities, neuromuscular reeducation, chiropractic manipulation, OV, Wrist x-ray, light therapy, biofreeze, TENS supplies, massage 12/29/04 – 8/19/05

Decision

I disagree with the carrier's decision to deny the requested services through 1/8/05, and I agree with the decision to deny the services after 1/8/05.

Rationale

A fair trial of conservative treatment would be medically appropriate and necessary. Four weeks, or twelve sessions failed to show efficacy with the patient. An enormous volume of repetitive daily notes from the D.C. was reviewed. The patient's subjective pain levels did not change during treatment. His VAS was 4-5/10 during the entire period in this dispute. Also, the area of pain did not change, except that the pain slowly moved up the arm and into the left shoulder. On 3/24/05, after about four months of treatment, the patient reported that his condition had become more painful. On 10/21/05, about a year after the patient began treatment with his D.C., his VAS was 5/10, with the same areas of pain as he had had a year earlier, with severe muscle trigger points on both wrists, hands and fingers. The D.C.'s objective assessments did not change during the treatment period.

As of 7/29/05 the patient reported that he was very limited in what he was able to do. He could not do any yard work, and had to ask family members to care for his household maintenance. He also stated that he could not return to work due to pain and weakness in his left hand. It was reported on 5/24/05 that the patient had significant weakness and pain that limited his ability to work, and for which he took Vicodin. The report also stated that the patient was not capable of doing anything other than sedentary work because of the debilitating injury to both hands, and that the patient would need surgery in the future.

The D.C. treatment failed to be of benefit to the patient, and failed treatment does not establish a medical rationale for the continued use of non-effective therapy. An initial trial of conservative treatment was appropriate, consisting of twelve sessions through 1/8/05. Treatment after the initial trial failed to show any subjective or objective improvement and was not reasonable or 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