



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	
Requestors Name and Address: JCMLR P O BOX 1660 San Antonio, Texas 78228	MDR Tracking No.: M5-06-1027-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Rep Box # 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: None submitted by Requestor

Principle Documentation:

1. DWC-60/Table of Dispute Services
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual requests that the request for dispute resolution filed by JCMLR, be conducted under the provisions of the APA....".

Principle Documentation:

1. Response to DWC-60
2. Explanation of Benefits

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
02-23-05 to 06-13-05	G0283 (1 unit @ \$13.61 X 9 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$122.49
	97140 (1 unit @ \$31.79 X 26 DOS)		\$826.54
	97110 (1 unit @ \$33.56 X 4 DOS)		\$134.24
	97110 (2 units @ \$67.12 X 16 DOS)		\$1,073.92
	TOTAL		\$2,157.19

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.

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 05-30-06, 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 97010 billed on dates of service 02-23-05, 02-25-05, 03-04-05, 03-08-05 and 03-11-05 were denied by the carrier with denial code 97 (payment is included in the allowance for another service/procedure). Code 97010 is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for code 97010 is included in the reimbursement for the comprehensive therapeutic code, therefore, reimbursement is not recommended. .

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1)
Texas Labor Code 413.031

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 \$2,157.19. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee \$650.00. The Division hereby **ORDERS** the Respondent 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:

07-24-06

Authorized Signature

Typed Name

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

June 27, 2006

Re: IRO Case # M5-06-1027-01 ____

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 physician who is Board Certified in Neurological Surgery, 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. Cervical spine MRI report 2/21/05
4. Reports, Dr. Youngblood
5. Lumbar spine MRI report 7/5/05
6. Electrodiagnostic test report 2/2/05
7. Neurosurgery follow up report, Dr. Lowry
8. Physical therapy records

History

The patient is a 54-year-old male who in ____ was injured while he was lifting something very heavy with his left shoulder. The patient developed neck and upper extremity pain. The patient had a history of injury in ____ that caused neck and arm pain, which resolved with physical therapy and medications. Recurrent neck pain occurred in association with the more recent injury, and this led to MRI, which showed changes compatible with surgical correction at C5-6 and C6-7. A C5-6 and C6-7 ACDF was carried out on 7/21/03. The patient's history also included back surgery in 1989 at the L4-5 level because of disk problems in the lumbar spine, and there was some recurrent back pain in association with the ____ injury, but this was less than the neck pain. Recurrent or continued neck pain occurred after initial improvement after the 7/21/03 surgery. A repeat cervical MRI on 2/21/05 showed changes in the cervical spine in areas other than the surgical area, which were compatible with the patient having significant discomfort in the neck, and possibly into his shoulders. Conservative measures included blocks in the cervical spine with steroids, along with physical therapy in association with those injections.

Requested Service(s)

Electrical stimulation, manual therapy technique, therapeutic exercises

2/23/05 – 6/13/05.

Decision

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

Rationale

It is fairly standard, and reasonable and necessary, to pursue physical therapy in association with injections in the neck. The patient had MRI findings that showed changes that are frequently associated with neck discomfort that can be relieved either by surgery, or by injections. Based on the records provided for this review and the patient's general status and previous surgery, a course of conservative management would be indicated before a surgical procedure would be pursued. This was carried out by way of injections, and in association with those injections, physical therapy measures, which are standard care.

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