



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: Valley Spine Medical Center 5327 South McColl road Edinburg, Texas 78539	MDR Tracking No.: M5-06-1121-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Liberty Mutual Fire Insurance Rep 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  
 POSITION SUMMARY: Per the table of disputed services "The care rendered to the patient has met criteria set by Texas Labor code section 408.21 complete rationale for increase reimbursement can be found in the medical records of the complete Medical Dispute".

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

DOCUMENTATION SUBMITTED: Response to DWC-60  
 POSITION SUMMARY: "Not medically necessary per peer review".

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

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
03-16-05	99215	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$142.75
04-29-05 to 06-30-05	99205, 97110, 97124, 97140, 99212 and G0283	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
<b>TOTAL</b>			\$142.75

#### 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.

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.

CPT code 99080-73 date of service 06-30-05 was denied with denial code "V/435" (based on peer review, further treatment is not recommended). Per Rule 129.5 the DWC-73 is a required report which is not subject to an IRO review. The Medical

Review Division has jurisdiction in this matter. Reimbursement is therefore recommended in the amount of \$15.00.

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

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 129.5

**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 \$157.75. 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:

04-20-06

\_\_\_\_\_  
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 13, 2006

**Re: IRO Case # M5-06-1121-01** \_\_\_\_

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. Request for reconsideration 2/11/06
4. Report 4/29/05, Dr. Zavala
5. Initial report 3/11/05, Dr. Flores
6. Report 3/16/05, Dr. Garcia
7. Therapeutic procedure charts
8. TWCC work status report 6/30/05

### History

The patient injured her low back in \_\_\_\_ when she bent over and twisted to pick up a 5-gallon container of paint. She was treated with chiropractic care and therapeutic exercises. She also received medication, and an MRI was obtained.

### Requested Service(s)

Office visits, therapeutic exercises, electrical stimulation, massage, manual therapy technique  
3/16/05 – 6/30/05

### Decision

I agree with the carrier's decision to deny the requested services after 4/28/05, and I disagree with the denial of the requested service prior to 4/28/05..

### Rationale

The patient had an adequate trial of chiropractic care from 3/11/05 – 4/28/05 without objective or subjective relief of symptoms or improved function. The D.C.'s notes fail to show any improvement in the patient's initial condition. On 6/3/05, after almost two months of treatment, the patient was still in constant, moderate pain and had difficulty standing, sitting, bending, lifting and sleeping.

According to the D.C.'s notes, the patient was having difficulty bending and lifting, yet the patient was doing exercises that would be contraindicated for a diagnosed lumbar HNP.

Active therapeutic exercises for strengthening and increasing flexibility should be based in successful passive treatment, which had failed under the D.C. Failed conservative treatment does not establish a medical rationale for the continued use of non-effective therapeutic treatment.

The D.C.'s treatment was over utilized and inappropriate after 4/28/05. The patient should have been on a home-based exercise program as of 4/28/05, some six weeks after treatment began. The treatment failed to be of any benefit to the patient, and failed to return the patient to work without restrictions. In fact the D.C. placed restrictions, extending another six months, through 12/30/05. The D.C.'s documentation fails to support the medical necessity of the services.

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