



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: Dr. Patrick R.E. Davis 115 W. Wheatland Road Ste 101 Duncanville, Texas 75116	MDR Tracking No.: M5-06-1160-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Benchmark Insurance Company Rep Box 17	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 Table of Disputed Services "Documentation supports medical necessity".

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)
04-14-05, 04-22-05, 05-11-05 & 06-10-05	E1399-NU (2 units @ \$32.00 X 4 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$128.00
05-03-05	E1399-NU (3 units @ \$48.00)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$48.00
05-26-05 & 06-24-05	E0745-RR (\$89.51 X 2 DOS)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$179.02
TOTAL			\$355.02

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 05-10-06, 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 codes 98940-25, 97140-59, 97112-59, 97116-29, 97110-59 as well as HCPCS codes E0745-RR and E1399-NU (with the exception of the dates of service which denied for medical necessity) billed on dates of service 04-04-05 through 05-26-05 were denied by the carrier with denial code W1(YL) (not treating doctor approved payment) or denied code W1(YN) (not documented). Review of the CMS 1500's submitted by the Requestor indicates the provider of services for the dates of service in dispute was listed as Kris Wilson, D.C. Dr. Wilson was not the treating doctor of record for these dates of service. In addition, per Rule 133.307(g)(3)(A-F) the Requestor did not submit documentation for review. No reimbursement is recommended.

Proof of payment of CPT codes 97140-59 (2 units), 98940-25 and 97112-59 billed on date of service 05-31-05 was submitted by the carrier via check number 00040347, therefore, these codes will not be a part of the review.

CPT code 97530-59 billed on dates of service 05-31-05 through 06-24-05 was denied by the carrier with denial code N (not documented). The Requestor did not submit any documentation for review per Rule 133.307(g)(3)(A-F), therefore, no reimbursement is recommended.

CPT code 97116-59 was listed on the Table of Disputed Services for dates of service 05-09-05, 05-13-05 and 05-18-05, however, no explanation of benefits was provided by the Respondent. Review of CMS 1500's revealed that the Requestor per Rule 133.307(e)(2)(A) did not provide copies of bills submitted to the Respondent for review. No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(g)(3)(A-F), 133.307(e)(2)(a) and 2005 DMEPOS Fee Schedule

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 \$355.02. In addition, the Division finds that the requestor was the prevailing party and is entitled to a refund of the IRO fee (\$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:

06-22-06

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

May 27, 2006

Re: IRO Case # M5-06-1160 -01 _ amended 6/20/06

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, Rule133.308 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. Review 1/12/05, 21/24/04, Dr. O'Kelly
4. Review 4/29/04, Dr. Cochran
5. Operative report 3/14/05
6. Report 5/25/04, 4/4/05, Dr. Davis
7. Rehabilitation notes, Dr. Davis
8. TWCC work status reports
9. Reports, Dr. Milani
10. X-ray and MRI reports cervical and lumbar spine
11. Electrodiagnostic report 7/19/04
12. Lumbar myelogram report 2/21/05
13. Operative report left knee 10/14/04
14. MRI report left knee 6/24/04

History

The patient injured his neck, low back and left knee when he was involved in a motor vehicle accident. The patient initially saw and M.D., but he was unhappy with his care and sought chiropractic treatment from a D.C. The patient had knee surgery on 10/7/04, and low back surgery on 3/14/05. He continued post-operative treatment with his D.C. for his lower back.

Requested Service(s)

Durable medical equipment, neuromuscular stimulator 4/14/05 – 6/24/05

Decision

I disagree with the carrier's decision to deny the requested DME and neuromuscular stimulator.

Rationale

The patient continues to benefit from the prescribed post-operative treatment plans, with noted improvements per the post-operative comprehensive physical examination, including sensational improvement across the lower extremity via pinwheel evaluation/light touch, improvements with lumbar active range of motion, improvements with muscle grade strength of the lower extremities, and marked improvements during designated orthopedic tests for the lumbar spine.

THE EMS unit is necessary to continue treatment to address post-operative spasms, effusion, and to discourage disuse atrophy. The objective improvements and subjective relief of symptoms indicate that the EMS unit was reasonable and necessary. The D.C.'s documentation is thorough and professionally presented and supports the continued use of the neuromuscular (EMS) stimulator. The TENS pads are necessary for the continued utilization of the EMS unit, and need to be replaced on a regular basis.

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