



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

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address: Jack P. Mitchell, D.C. P.O. Box 9159 Longview, TX 75608	MDR Tracking No.: M5-06-1207-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: American Motorists Insurance Company, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "The provider is now respectfully requesting reimbursement in full for the aforementioned services."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "Per peer review no chiro care after 1-3-02."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-23-05	CPT code 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$59.00
11-23-05	CPT code G0283	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$13.61
11-23-05	CPT code 98941	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$43.00
11-23-05	HCPCS Code A4556 (see below)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	0
	Grand total		\$115.61

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 prevail on the medical necessity issues. The amount due the requestor for the items denied for medical necessity is \$115.61.

Per the DMEPOS HCPCS fee schedule Code A4556 is a bundled code and won't be paid separately.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202(c)(1).
DMEPOS HCPCS Fee Schedule

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the carrier must refund the amount of the IRO fee (\$460.00) to the requestor within 30 days of receipt of this order. The Division has determined that the requestor is entitled to additional reimbursement in the amount of \$115.61. 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.

Findings and Decision and Order by:

Donna Auby, Medical Dispute Officer

5-5-06

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

April 26, 2006

Re: IRO Case # M5-06-1207-01 ____

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. Review 1/3/02, Dr. Wagner
4. Request for Reconsideration 4/6/06, Dr. Mitchell
5. Notice of IRO decision 12/30/03
6. Treatment notes, Dr. Mitchell
7. IMEs 2/12/02, 11/9/99, Dr. Fino
8. Nerve conduction report 4/10/00
9. RME TWCC 7/9/1
10. IR report 7/9/01, Dr. Mitchell
11. Discography report
12. CT report of lumbar spine 3/5/01
13. Chart notes, Dr. Bolnick
14. MRI lumbar spine report 9/8/99
15. Radiology report lumbar spine 9/12/99
16. DD report 8/23/01, Dr. Curtis

History

The patient injured his lower back in _____. He has been treated with extensive chiropractic treatment, medication and epidural steroid injections.

Requested Service(s)

Office visit, electrical stimulation, chiropractic manipulation, electrodes 11/23/05.

Decision

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

Rationale

The records provided for this review show that the patient received treatment for exacerbation of the lumbar HNP from the ___ injury. The documentation provides sufficient subjective complaints and objective findings to support treatment. It is also documented that the patient's home-based exercises and OTC medications had failed to relieve the patient's symptoms. Therefore, a short course of up to five visits would be reasonable and necessary to relieve symptoms. The records for 1/25/05 state that the patient called and cancelled his visit, stating that his pain had resolved, indicating that treatment was beneficial. Based on the records provided for review, treatment was not over utilized and was cost effective and appropriate, resulting in relief of symptoms. The patient met the clinical indication for treatment with passive modalities such as was provided on 11/23/05, in that this treatment limits the severity of recurrent episodes of pain.

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