



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: REHAB 2112 P O BOX 671342 Dallas, Texas 75267-1342	MDR Tracking No.: M5-06-1651-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Dallas National Insurance Rep Box # 20	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: Per the Table of Disputed Services "Services are medically necessary."

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "Contrary to Requestor Rehab 2112's allegations, Carrier has made a valid and legal determination that the treatment/services in question were not reasonable and medically necessary, pursuant to the Texas Department of Insurance, Division of Workers' Compensation (DWC) medical fee guidelines and/or rules and statutes".

Principle Documentation: Response to DWC-60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
05-02-05 to 06-22-05	97110, 97545-WH-CA and 97546-WH-CA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00

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 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.

Review of the explanation of benefits for CPT code 97750-FC billed on 05-02-05 and listed on the Table of Disputed Services revealed that the service had been paid by the Respondent. The Requestor was contacted on 07-12-06 and verification was made that no payment had been received. Reimbursement is recommended per Rule 134.202 in the amount of **\$444.00**.

Review of the explanation of benefits for CPT code 97110 (4 units) billed on 05-10-05 and listed on the Table of Disputed Services revealed that the service had been paid by the Respondent. The Requestor was contacted on 07-12-06 and verification was made that no payment had been received. Reimbursement is recommended per Rule 134.202 in the amount of **\$144.56**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308 and 134.202
Texas Labor Code, Sec. 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 **\$588.56**. In addition, 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 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:

07-26-06

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

July 6, 2006

Re: IRO Case # M5-06-1651 -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. RME 9/12/05, Dr. Osborne
4. Review 5/4/05
5. FCE reports 5/26/05, 5/2/05
6. Records, therapy notes, reports, psychological group note, exercise log sheets, Dr. Rayshell
7. WH/WC daily notes
8. MDR request 4/10/06
9. MRI report 4/15/05
10. Letter of medical necessity 2/8/06
11. Report 4/28/05, Dr. Wise
12. Reports, Concentra

History

The patient is a 39-year old male who was injured in ____ when he was hit in the hip area. He initially went to Concentra and was diagnosed with a sacroiliac contusion. He later received chiropractic care. He has been treated with chiropractic care, medication, and therapeutic exercises. He has had x-ray and MRI evaluation.

Requested Service(s)

Therapeutic exercises, work hardening program 5/2/05 - 6/22/05.

Decision

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

Rationale

The patient had an unsuccessful trial of conservative care prior to the dates in this dispute without relief of symptoms or improved function. The D.C.'s treatment plan was not appropriate for the condition being treated. The D.C. diagnosed the patient with a lumbar sprain/strain, but the records provided for this review do not indicate that the patient ever really had lower back pain. Objective signs and tests, such as lumbar ROMs, palpations and orthopedic testes failed to support the diagnosis. If lumbar surgery had been suspected, why was an MRI of the right hip ordered, and not an MRI of the lumbar spine? The Concentra diagnosis of contusion of the sacroiliac joint and right hip appears from the records to be a correct diagnosis.

Proper treatment should have included ice massage, ultrasound, chiropractic manipulation of the right sacroiliac joint, and stretching in the acute stage, followed by deep tissue techniques, ultrasound, manipulation and passive and active stretches and exercises. There should have been resolution within six weeks. The D.C.'s notes failed to show the use of ultrasound, massage, electrical muscle stimulation or manipulation. The treatment was inappropriate, and it failed. The patient should have been on a home-based exercise program within six weeks post injury.

A WH/WC program is based on the successful completion of previous conservative treatment. Given the patient's poor response to the D.C.'s initial treatment, a WH/WC program would not be reasonable and necessary.

The D.C.'s documentation was poor, being illegible at times, and lacking subjective complaints and objective findings to support his diagnosis and treatment.

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