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 Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: Southeast Health Services P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-06-1749-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Rep Box # 42	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: No Position Summary was submitted to MDR by the Requestor.
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: No Position Summary was submitted to MDR by the Respondent.
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)
06-21-05 to 07-14-05	99211 ($28.28 X 7 DOS)	☒ Yes ☐ No	$197.96
06-21-05 to 07-14-05	97032 (1 unit @ $20.53 X 10 DOS)	☒ Yes ☐ No	$205.30
06-21-05 to 07-14-05	97016 (1 unit @ $18.18 X 10 DOS)	☒ Yes ☐ No	$181.80
06-23-05 to 07-14-05	97530 (2 units @ $72.00 X 9 DOS)	☒ Yes ☐ No	$648.00
06-23-05 to 07-14-05	97140-59 (1 unit @ $34.16 X 8 DOS)	☒ Yes ☐ No	$273.28
06-28-05 & 07-13-05	98940 (1 unit @ $33.61 X 2 DOS)	☒ Yes ☐ No	$67.22
07-05-05	99080-73	☒ Yes ☐ No	$15.00
07-07-05	99214	☒ Yes ☐ No	$107.01
	TOTAL		$1,695.57

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 disputed medical necessity issues.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.1 and 134.202
Texas Labor Code, Sec. 413.031 and 413.011 (a-d)

PART VII: DIVISION FINDINGS 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 $1,695.57. In addition, the Division finds that the Requestor was the prevailing party and is entitled to a refund of the IRO fee in the amount of $460.00. 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.

Order by:

		08-24-06
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.

IRO America Inc.

An Independent Review Organization
7626 Parkview Circle
Austin, TX 78731
Phone: 512-346-5040
Fax: 512-692-2924

Amended Decision August 24, 2006
July 24, 2006

TDI-DWC Medical Dispute Resolution
Fax: (512) 804-4868

Patient:
TDI-DWC #:
MDR Tracking #: M5-06-1749-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Chiropractic Care. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including but not limited to: IRO request; 4-pages MDR Request; 9-pages denied EOBs for services from Southeast Health Services; 2-pages LOMN for disputed services Dr. Bryan Weddle dated 1-20-06; 2-page Daily Soap Notes dated 6-21-05, 6-23-05, 3-pages dated 6-24-05, 6-28-05, 6-30-05, 3-pages dated 7-5-05, 3-pages dated 7-6-05, 4-pages dated 7-7-05, 7-13-05, 7-14-05.

CLINICAL HISTORY

The Patient sustained a work related injury on while working for The Reviewer is not sure of the specifics as related to the mechanism of injury, as the records provided did not provide details. Disputed dates of service were from June 21, 2005 to July 14, 2005. MRI of the cervical spine dated 5-21-2005, revealed a 2mm disc protrusion/herniation at C4-5 with mild IVF narrowing, a 3mm disc protrusion/herniation at C5-6 with mild right IVF narrowing, a 2mm disc protrusion/herniation at C6-7 with severe IVF narrowing. MRI of the lumbar spine revealed a 3mm disc protrusion at L2-3, a 2-3mm disc herniation at L3-4, a 1-2mm disc protrusion at L4-5, and a 2mm disc protrusion/herniation at L5-S1. The Patient was treated with passive and active therapies including Matrix and DRX decompression. Services dates 6-21-2005 to 7-14-2005 were denied by carrier as unnecessary treatment based on peer review; however, no peer review was provided or attached.

DISPUTED SERVICE(S)

Under dispute is the retrospective medical necessity of office visits-99211/99214, electrical stimulation-97032, vasopneumatic devices-97016, chiropractic manipulative treatment-98940, special reports-99080-73, manual therapy-97140-59, and therapeutic acticities-97530 for the dates 6/21/05 through 7/14/05.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

Based on the clinical evidence and documentation, The Reviewer's medical assessment is that the disputed services (office visits-99211/99214, electrical stimulation-97032, vasopneumatic devices-97016, chiropractic manipulative treatment-98940, special reports-99080-73, manual therapy-97140-59, and therapeutic acticities-97530 from DOS 6-21-2005 through 7-14-2005.) were medically necessary. The Patient has a positive MRI of the cervical and lumbar spine for disc pathology and stenosis. Services were medically necessary in the treatment and recovery of the work related injuries.

Screening Criteria

General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case,

which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literate and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee's policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by facsimile, a copy of this finding to the DWC.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Your Right To Appeal

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 the 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 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 it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to DWC via facsimile, on this 24th day of July, 2006.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer