



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestor's Name and Address: Allied Behavioral Healthcare P O BOX 257 Ferris, Texas 75125	MDR Tracking No.: M5-07-0188-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name: TPCIGA For Legion Insurance Company Rep Box # 50	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "The attached claim was pre-authorized for 10 days of Chronic Pain Management then submitted by ABHI once and denied, and submitted a second time as a reconsideration and denied (see attached EOB's). We have yet to receive any payment."

Principle Documentation: 1. DWC 60 package
2. CMS 1500's
3. Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "A PLN-11 was filed on April 6, 2006 based on the RME doctor's opinion, disputing the current medical condition as being unrelated as this is due to cervical and lumbar degenerative disk disease, which is unrelated to the compensable injury of
The claimant has not requested a Benefit Review Conference to pursue any of the extent of injury disputes to date. TPCIGA will maintain the extent of injury disputes until the claimant pursues the disputes and have been finally adjudicated by Texas Department of Insurance, Division of Workers' Compensation."

Principle Documentation: 1. Response to DWC 60

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
08-07-06, 08-08-06, 08-09-06 and 08-17-06	W9/W12	97799-CP (\$800.00 X 4 DOS)	(1-5)	\$3,200.00
TOTAL DUE				\$3,200.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Division Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

- RME
- The Respondent denied the services with denial codes "W9" (unnecessary medical treatment based on peer review) and "W12" (extent of injury, not finally adjudicated. Service is unrelated to the compensable injury per RME report attached).
 - The Respondent filed a PLN-11 disputing psychological conditions and depression, however, the Requestor has not billed for these diagnoses. In addition, at a Contested Case Hearing on 04-29-05 it was determined that the compensable injury does not include bilateral carpal tunnel syndrome, cervical radiculopathy, bilateral cubital tunnel syndrome or hypertension. The Requestor did not bill for these diagnoses.

- (3) The Requestor obtained preauthorization for the services prior to the services being rendered (preauthorization number 182-87119 A1).
- (4) Per Rule 134.600(b)(1)(B) the carrier is liable for all reasonable and necessary medical costs relating to the health care if preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care.
- (5) Reimbursement is recommended per Rule 134.202(e)(5)(ii) in the amount listed above.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d)
 28 Texas Administrative Code Sec. §134.1
 28 Texas Administrative Code Sec. §134.202(e)(5)(ii) and 134.600(b)(1)(B)

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 **\$3,200.00**. 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:

11-20-06

 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
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Austin, Texas 78758

PH. 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 5, 2006

Re: IRO Case # M5-07-0188 -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 the Division of Workers' Compensation assign cases 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 injured employee's 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. Report 3/20/06
4. HICFA form, Dr. Duncan
5. Preauthorization 1/24/06
6. Group therapy note
7. Biofeedback notes
8. Group progress notes
9. Psychotherapy notes
10. Treatment recommendation reports 8/22/06, 9/14/06, Allied Behavioral healthcare
11. Report 4/11/06, MBMD
12. Treatment notes, Dr. Rodriguez

History

The patient suffered neck and low back injuries in 2000, while pulling pipes out of the ground. Treatment has included physical therapy, chiropractic care, medication, injections, and a chronic pain management program.

Requested Service(s)

97799 Unlisted physical medicine/ rehabilitation services or procedure 8/7/06 – 8/17/06

Decision

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

Rationale

The patient initially injured his low back and neck in 2000. he was diagnosed with a lumbar and cervical sprain/strain injury. This should have resolved with appropriate treatment in 2-3 months. However, his symptoms still persist after some six years. It was reported that the patient had some pre-existing degenerative changes to the cervical and lumbar spine, but no MRI reports were available in the materials provided for this review.

The patient had subjective complaints and objective findings from the time of injury to support traumatic radiculopathy of the cervical and lumbar spinal areas. Muscle weakness, positive orthopedic tests, paresthesia and muscle atrophy all have been objectively noted over the years since the injury.

Improper diagnosis and inappropriate treatment led to chronic pain, which required proper management. Reports, daily notes, and treatment plans for the disputed services support the chronic pain management program. Symptoms decreased and function increased. His pain level decreased from 9-10/10 to 5-7/10 without prescribed medication.. his physical activity level increased.

His depression and anxiety responded to treatment. His compliance was noted as being very good, and the patient is trying to find work that he is physically capable of doing.

The documentation provided for this review demonstrates consistent improvement, and supports the fact that the patient was asymptomatic prior to his injury. The documentation also supports that the care prior to the CPMP was ineffective in reducing pain and improving function. Therefore, the disputed services were reasonable and necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Worker's Compensation decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have a 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 the district clerk in Travis County (see Texas Labor Code sec. 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.

Daniel Y. Chin, for GP