



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: () Health Care Provider (X) Injured Employee () Insurance Carrier

Requestor's Name and Address:

David V. Dent, DO PA
P.O. Box 362
Palestine, TX 75802

MDR Tracking No.:

M5-07-0371-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

AMERISURE INSURANCE CO, BOX 47

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary (Table of Disputed Services): "Svs medically necessary to relieve effects caused by compensable injury... Carrier refused to reconsider because order was issued on 4-21-06."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "Our office received the Medical Interlocutory Order dated April 21, 2006 stating that for 3 months from the date of the order we must pay for medication... We paid for all treatment and medication for this 90 days period April 21, 2006 through July 21, 2006. We disputed any medical treatment prior to the date of the order and anything after the expiration of the order."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

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)
12-12-05 - 4-19-06	99213, 99214, 99080-73	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
Total Due			\$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.

CPT code 99080-73 on 4-19-03 was withdrawn by the Requestor in an e-mail dated 2-5-07. These services will not be a part of this dispute.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

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

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 Division has determined that the Requestor is not entitled to reimbursement for the IRO and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

Medical Dispute Officer

02-13-07

Authorized Signature

Typed Name

Date of Findings and Decision

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.

AMENDED February 12, 2007

SENT TO: Texas Department of Insurance
Health & Workers' Compensation Network Certification & QA
Division (HWCN) MC 103-5A
Via Fax: 512.804.4868

02/01/07

RE: IRO Case #: M5.07.0371.01
Name:
Coverage Type: Workers' Compensation Health Care - Non-network
Type of Review:

Preauthorization
 Concurrent Review
 Retrospective Review
Prevailing Party:
 Requestor
 Carrier

Independent Review, Inc. (IRI) has been certified, IRO Certificate # 5055, by the Texas Department of Insurance (TDI) as an Independent Review Organization (IRO). TDI has assigned this case to IRI for independent review in accordance with the Texas Insurance Code, the Texas Labor Code and applicable regulations.

IRI has performed an independent review of the proposed/rendered care to determine if the adverse determination was appropriate. In the performance of the review, IRI reviewed the medical records and documentation provided to IRI by involved parties.

This case was reviewed by a D.C., D.O., M.S., Board Certified, Chiropractic, Physical Medicine Rehabilitation, Pain Management. The reviewer 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 (URA), and any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

As an officer of IRI, I certify that:

1. there is no known conflict between the reviewer, IRI and/or any officer/employee of IRI with any person or entity that is a party to the dispute, and
2. a copy of this IRO decision was sent to all of the parties via U.S. Postal service or otherwise transmitted in the manner indicated above on 02/01/07.

RIGHT TO APPEAL:

You have the right to appeal the decision by seeking judicial review. This IRO decision is binding during the appeal process.

For disputes other than those related to prospective or concurrent review of spinal surgery, the appeal must be filed:

1. directly with a district court in Travis County (see Labor Code 413.031(m)), and
2. within thirty (30) days after the date on which the decision is received by the appealing party.

For disputes related to prospective or concurrent review of spinal surgery, you may appeal the IRO decision by requesting a Contested Case Hearing (CCH). A request for CCH must be in writing and received by the Division of the Workers' Compensation, Division Chief Clerk, within ten (10) days of your receipt of this decision.

Sincerely,

Jeff Cunningham, D.C.
Director of Operations

**REVIEWER REPORT
M5 07 0371 01**

DATE OF REVIEW: 01/30/07

IRO CASE #: M5-07-0371-01

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Office visits codes 99213 and 99214 and special reports 99080-73 from 12/12/05 through 04/19/06

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., D.O., M.S., Board Certified, Chiropractic, Physical Medicine Rehabilitation, Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Notes from 12/12/05, 01/20/06, 03/15/06, 04/19/06, and 07/09/06
2. Note dated 03/26/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

On _____ the injured employee made a claim of low back pain secondary to sitting on a high chair while sewing. She was at that time diagnosed with a right sacroiliac joint problem as well as a possible left lumbosacral radiculopathy. There were no EMG studies or MRI scans available in the records for my review. She did have a lumbar epidural steroid injection on 11/24/98. There was then a 5-year hiatus until treatment was reinitiated. At that time, according to documentation, she was having symptoms in the opposite right leg as opposed to the left leg as noted initially in 1995.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

It would appear as though she initially had a right sacroiliac joint dysfunction with suggestion of left lumbosacral radiculopathy. I do not, however, have the electrodiagnostic studies or MRI imaging studies to correlate with that history. She apparently was last treated on 11/24/98 with a lumbar epidural steroid injection, and there was thereafter a hiatus of 5 years before she was seen again. She was complaining of pain in her right leg when she was treated in the latter part of 2005 and through the summer of 2006. Reference is made to an MRI scan showing a herniated disc and a positive EMG study, although those records are not part of my file. It should be noted, however, that it appears that the more recent symptomatology extends into the right leg, where initially the symptoms were in the left leg. It is my opinion that the 99213, 99214, and 99080 office visits are not supported as being medically necessary for the _____ work incident.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.

AHCPR-Agency for Healthcare Research & Quality Guidelines.

DWC-Division of Workers' Compensation Policies or Guidelines.

European Guidelines for Management of Chronic Low Back Pain.

Interqual Criteria.

Medical judgement, clinical experience and expertise in accordance with accepted _____ medical standards.

Mercy Center Consensus Conference Guidelines.

Milliman Care Guidelines.

ODG-Official Disability Guidelines & Treatment Guidelines.

Pressley Reed, The Medical Disability Advisor.

Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.

Texas TACADA Guidelines.

TMF Screening Criteria Manual.

Peer reviewed national accepted medical literature (provide a description).

Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)