

MDR Tracking Number: M5-05-0573-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-19-04.

The IRO reviewed office visits, electrical stimulator supplies, electrodes, self care management training, electric heat pad, ice cap, electrical stimulation unattended, manual therapy, therapeutic exercises, hot-cold pack, neuromuscular stimulator, ultrasound therapy rendered from 03-25-04 through 07-09-04 that were denied based upon "V".

The IRO determined that the electrical stimulation unattended **was not** medically necessary and all other requested items and services **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 the Medical Review Division.

On 11-30-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT codes 97750, 97140, 97110, 99214 codes and HCPCS codes A4556-NU and A4630-NU for dates of service 05-03-04, 05-07-04, 05-10-04, 06-08-04, 06-15-04, 06-29-04, 06-30-04 and 07-01-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

CPT code 99080-73 date of service 07-09-04 denied with denial code "U" (unnecessary medical treatment or services). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. Reimbursement is recommended in the amount of **\$15.00**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

This Findings and Decision is hereby issued this 9th day of March 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 03-25-04 through 07-09-04 in this dispute.

This Order is hereby issued this 9th day of March 2005.

Margaret Ojeda, Manager Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

MQO/dlh

Enclosure: IRO Decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020

Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 3, 2005

Re: IRO Case # M5-05-0573-01
Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 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 TWCC assign cases to certified IROs, TWCC assigned this case 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 physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and 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. Office notes Dr. Dillin
4. Medical records dr. Strathdee
5. Medical therapy progress notes
6. Operative reports 3/31/04, 6/16/04 Dr. Dillin
7. Daily physical therapy notes
8. MRI left knee and left elbow reports 2/17/04
9. Left knee arthrogram and CT arthrogram 3/11/04
10. EMG/NCS 3/21/04
11. FCE report 8/3/04
12. PPE reports 6/8/04, 5/3/04, 3/9/04
13. Peer review 2/20/04 Dr. Bottorff

History

The patient is a 38-year-old male who in ___ slipped on wet concrete and fell, injuring his left knee and elbow. The patient suffered a twisting injury to the knee, and a direct impact on the elbow. The patient was treated conservatively at first, and then was referred to an orthopedic surgeon for evaluation. X-rays of the knee and

elbow were reportedly normal. An MRI of the knee was essentially normal. Arthroscopic CT evaluation of the knee was negative for a meniscus tear. The patient underwent left knee arthroscopy and multi-compartment synovectomy, including resection of the lateral aspect of the ACL and medial plica with anterior compartment synovectomy on 3/31/04. The patient began post surgical rehabilitation the following week.

A 2/17/04 MRI of the left elbow showed intra-articular joint space effusion, partial thickness tear, tendinosis/tendinopathy and reparative changes involving the distal extent of the triceps tendon, tendinosis/tendiopathy of the common flexor and common extensor tendons, inflammatory changes within the cubital tunnel without evidence for nerve entrapment. A 4/20/04 CT scan of the elbow was normal. EMG/NCS evaluation on 3/21/04 revealed a mild left ulnar neuropathy of the elbow. The patient underwent left ulnar neurolysis with medial epicondylectomy on 6/16/04 for left cubital tunnel syndrome with medial epicondylitis. Following surgery he started on a post operative rehabilitation program.

Requested Service(s)

Office visit, electrical stimulator supplies, electrodes, self care management training, electric heat pad, ice cap, electrical stimulation unattended, manual therapy, therapeutic exercises, hot-cold pad, euromuscular stimulator, ultrasound 3/25/04 – 7/9/04

Decision

I agree with the carrier's decision to deny the requested unattended electrical stimulation, and I disagree with the decision to deny all of the other requested items and services.

Rationale

The patient was issued a home electrical stimulation unit, and electrical stimulation unattended G0283 would not be necessary if the patient was using his home unit.

The patient was scheduled for surgery on the knee. DME charged on 3/25/04 for use in the post operative period is medically acceptable and would be beneficial to the patient.

The patient underwent physical therapy in the post operative period following knee surgery on 3/31/04 and following elbow surgery on 6/16/04. Daily therapy following knee surgery for the first week post operatively is appropriate, followed by a decrease to three times per week for four to six weeks, followed by a taper to less frequent treatment. The dates of the disputed treatment following elbow surgery include 7/2/04 – 7/9/04.

Physical therapy in this post operative period for a one-hour session three times per week would also be medically necessary and appropriate.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Daniel Y. Chin, for GP