MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** (X) Yes ( ) No
Requestor's Name and Address Houston Pain & Recovery C/o Bose Consulting, LLC P O Box 550496 Houston, Texas 77255	MDR Tracking No.: M5-05-1896-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Home Assurance Co Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
03-19-04	**04-22-04**	**99212-25, 97032, 97035, 97112-59, 97150, 97140-59, 97110-59 and E1399**	☐ **Yes** ☒ **No**

PART III: 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 Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The requestor submitted an updated table of disputed services on 04-12-05 which will be used for this review.

Dates of service 09-05-03 through 02-06-04 per Rule 133.308(e)(1) were not timely filed and will not be a part of the review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did not** prevail on the disputed medical necessity issues.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is not** entitled to reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		07-19-05
Authorized Signature		Date of Decision

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in 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 8, 2005

Re: IRO Case # M5-05-1896 –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 the TWCC 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 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. Peer reviews CONSILIUM MD
4. DDE 10/8/04, Dr. Levine
5. Peer review 8/29/04, Dr. Bigos
6. FCE reports 2/8/03, 5/23/04, 8/26/04
7. MRI cervical spine report 1/20/03
8. MRI left shoulder report 10/10/02
9. X ray cervical spine report 8/22/02
10. EMG/NCS upper extremity report 4/23/03
11. Orthopedic consultation report 10/17/03 Dr. McAlister
12. Orthopedic report 4/14/04, Dr. Berliner
13. Follow up office visit reports 7/15/04, 6/17/04, Dr. Payan
14. Operative report 5/25/04, Dr. Payan
15. Initial visit evaluation 5/6/04, Dr. Payan
16. Occupational therapy notes 11/18/02 – 12/13/02
17. Evaluation 12/10/02, Dr. Lintner
18. Initial evaluation 10/16/03, C. Meekins
19. Medical reports, Dr. Torres
20. Daily SOAP notes, Dr. Torres

History

The patient is a 38-year-old female who in ___ was lifting some heavy boxes when she felt a pop and the immediate onset of left shoulder and neck pain. She was taken to an ER where she was evaluated and x-rays were taken. She was given OTC medication and released. She began treatment with her treating D.C. in August 2003. The patient was treated with occupational therapy in November and December 2002. The patient was evaluated on 12/10/02 and non surgical treatment, including the continuation of

therapy was recommended. A 1/20/03 MRI of the cervical spine indicated dessication of cervical disks with very early posterior osteophyte formation at C5-6, and symmetrical increase in adipose tissue in the left supraclavicular region. A 10/10/02 MRI of the left shoulder found findings consistent with tendonitis of the infraspinatus component of the rotator cuff tendon. X-rays of the cervical spine, AC joint and shoulder were unremarkable. EMG/NCS of the evaluation of the upper extremities on 4/23/03 found only rare fibrillation potentials in the paraspinal level on the left at C5-6. A 10/17/03 orthopedic evaluation led to a recommendation of continued physical therapy, antinflammatory medication, pain management and cervical epidural steroid injections. In addition, the patient's shoulder was injected. On 5/6/04 a cervical epidural steroid injection was performed at C7-T1. In follow up on 6/17/04 excellent results from the injection were noted, and a repeat injection was recommended. However, one month later, on 7/15/04, the results of the epidural were described as mild, and a discogram was ordered. Therapy treatment with the treating D.C. continued through 7/29/04. On a 3/23/04 FCE the patient demonstrated the ability to function at a light physical demand level.

Requested Service(s)
99212-25 office visit, electrical stimulation, ultrasound, neuromuscular re-education, group therapeutic exercises, manual therapy technique, therapeutic exercises, DME 3/19/04 – 4/22/04

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

Rationale
The patient's injury occurred in ___. This was about 19 months prior to the dates of the disputed services. The medical records provided for this review show that the patient had already undergone over 50 prior therapy visits from various providers, and the notes do not indicate that the patient received any significant, lasting benefit from the physical therapy. Furthermore, the documentation provided for this review does not show continuing improvement on objective measures of range of motion, strength and function that would justify therapy. The records so not show a trend of improvement and do not show any reason why the patient could not have been independent on a home exercise program after the extensive therapy already provided. There is no identifiable reason why further monitored therapy would be required fort his patient. In addition, there is an unexplained gap in treatment 2/6/04 – 3/19/04 with no plan of care documented, and the records do not explain the need for the physical therapy in this dispute.

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

Sincerely,

_____
Daniel Y. Chin, for GP