

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Humpal Physical Therapy 5026 Deepwood Circle Corpus Christi, Texas 78415	MDR Tracking No.: M5-05-1903-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address New Hampshire Insurance Company 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		
04-28-04	07-14-04	G0283, 97113, 97112 and 97110	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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 Division has reviewed the enclosed IRO decision and determined that the requestor did **not** prevail on the disputed medical necessity issues.

CPT code 97002-25 for date of service 07-12-04 listed on the table of disputed services is not valid with the 25modifier.

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:

Debra L. Hewitt

06-22-05

Authorized Signature

Typed Name

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

June 17, 2005

Re: IRO Case # M5-05-1903 -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. Letter of medical necessity 7/22/04, R. Solecki
4. Internal peer review, 9/23/04, R. hanks
5. Physical therapy treatment records and progress notes
6. Progress notes, Dr. Agarwal
7. TWCC 69 and Disability evaluation 9/1/04, Dr. LeCompte
8. Hospital history and physical 1/13/04

History

The patient is a 25-year-old male who was in a motor vehicle accident in ____, and suffered a hip dislocation, posterior acetabular fracture and left femoral head fracture. He underwent surgery on 1/12/04, including an open reduction internal fixation of the left acetabular fracture, an open reduction of the left proximal femur fracture, and an open reduction of the hip dislocation. The patient's post operative course was unremarkable, except for some wound breakdown, which was treated. At his three month follow-up, the patient's surgeon noted that the patient was "doing well." There was some decrease in range of motion. The patient was allowed to weight bear as tolerated, and he was given a prescription for physical therapy.

Requested Service(s)

Electrical stim unattended, aquatic ther, neuromuscular reeducation, therapeutic exercises 4/28/04 – 7/14/04.

Decision

I disagree with the carrier's decision to deny the requested services on 4/28/04, 4/29/04, 4/30/04, and 4 units of 97113 on 6/1/04; 97112 on 6/2/04; 97110 on 6/3/04, 6/9/04, 6/10/04, 6/11/04, 6/14/04, 6/15/04; 4 units of 97110 on 6/17/04, 6/21/04, 6/22/04, 6/24/04 and 6/28/04. I agree with the decision to deny the other requested services

Rationale

The patient suffered severe injury to his left hip, with severe, documented deficits in strength and range of motion. Two months of physical therapy to restore the patient's strength and range of motion would be medically necessary. However, it would not be medically necessary to be treated for more than 45 – 60 minutes per session three times per week. Passive modalities should not take up more than 25 % of that time. Services that exceed this amount of time exceed accepted guidelines. By 6/30/04 the patient had completed two months of supervised physical therapy. The therapy records indicate that the patient was 85% better, with a near 5/5 strength in all muscles tested, and he was able to tolerate squatting at 45 degrees. At that point he should have been able to be discharged to a home exercise program to continue to progress his strength, endurance and range of motion.

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

Sincerely,

Daniel Y. Chin, for GP