

## 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 Southwest Health Services, Inc. P O BOX 453062 Garland, Texas 75045	MDR Tracking No.: M5-05-2085-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance 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		
04-27-04	11-09-04	<b>98940, 98941, 97032, 97110, 97035 and 98943 (not calculated in total as this code is noncovered by Medicare)</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
04-27-04	11-09-04	<b>97140, 99214, 97016, 97150, 99211, 97113, 97545-WH, 97546-WH and A9150-NU</b>	<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** prevail on the **majority** of disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$3,502.06**.

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 04-25-05, 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.

CPT codes 98941, 97032, 97016, 97035, 97012 and 97039-CM date of service 04-17-04 denied with denial code "L/242" (not treating doctor). The provider of the services was not the treating doctor of record. No reimbursement is recommended.

CPT code 98940 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$33.61**.

CPT code 98943 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service, however, this code is noncovered by Medicare. No reimbursement is recommended.

CPT code 97140-59 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$34.13**.

CPT code 97032 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$20.20**.

CPT code 97016 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$18.40**.

CPT code 97035 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$15.84**.

CPT code 97012 date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$19.21**.

CPT code 97113 (2 units) date of service 05-12-04 denied with denial code "N/710" (not documented/charge is being disallowed as additional/supporting documentation is required to clarify service/supply rendered). The requestor submitted documentation per Rule 133.307(g)(3)(A-F) to support delivery of service. Reimbursement recommended in the amount of **\$84.98**.

CPT code 99080-73 date of service 09-01-04 denied with denial code "U" (unnecessary treatment without peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. 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.

The total amount of reimbursement due from the carrier for the fee issues equals **\$241.37**.

**PART IV: COMMISSION DECISION**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services totaling \$3,743.43 in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

**Findings and Decision by:**

Debra L. Hewitt

06-23-05

Authorized Signature

Typed Name

Date of Findings and Decision

**Order By:**

Margaret Ojeda

06-23-05

Authorized Signature

Typed Name

Date of Order

**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 9, 2005

**Re: IRO Case # M5-05-2085 –01** \_\_\_ amended 6/21/05 due to addition of items on Notification of IRO assignment

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 Doctor of Chiropractic who is licensed in Texas, 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 from Consilummed
4. Employers first report of injury
5. IR report 11/18/04

6. TWCC 69 4/18/04
7. Reports 9/30/04, 8/23/04 Dr. Osborne
8. FCE 8/23/04
9. Letter of medical necessity, Dr. Weddle
10. Electrodiagnostic report 9/30/04
11. PPEs 8/31/04, 7/14/04
12. MRI report 4/21/04
13. Treatment notes, Dr. Weddle
14. Reports, Dr. Willis

#### History

The patient injured her neck and back in \_\_\_ when she slipped and fell. She was treated with chiropractic manipulation, therapeutic exercises, aquatic therapy, trigger point injections and medication. EMG and MRI evaluations were performed.

#### Requested Service(s)

Chiropractic manipulation, electrical stimulation, ultrasound, office visit established patient, therapeutic exercises, group therapeutic exercises, aquatic therapy, vasopneumonic device therapy, mechanical traction, manual therapy, exper non-prescript drugs, work hardening, work hardening each additional hour 4/27/04 – 11/9/04

#### Decision

I disagree with the carrier's decision to deny the requested chiropractic manipulation, electrical stimulation, ultrasound aquatic therapy, and therapeutic exercises (97110) only, and I agree with the denial of all other requested items.

#### Rationale

Based on the records provided for this review, the patient began treatment with the treating D.C. in mid-April 2004. Conservative active and passive therapy continued on a regular basis through mid July 2004, after which work hardening was initiated. Based on the records provided, the patient apparently suffered a strain injury, which should have resolved with proper treatment in 8 – 12 weeks. However, as of November 2004 she was still symptomatic, showing little relief of symptoms or improved function.

It appears from the records that the D.C. used about every form of passive modalities, which would be excessive.

The use of manipulation, therapeutic exercises, electrical stimulation, ultrasound, and aquatic therapy were reasonable and necessary for the dates in dispute. The necessity for the other services was not supported by the documentation and based on the records provided would be excessive. Mechanical traction, vasopneumonic device therapy and manual therapy duplicate the effects of manipulation, ultrasound and muscle stimulation. The patient's response to therapy was limited. The patient deserved an initial trial of conservative treatment, which was somewhat beneficial.

The use of a work hardening/conditioning program was not reasonable and necessary. Given the patient's limited response to a supervised therapy program, a work hardening/conditioning program would not be medically indicated. The need for such a program is usually based on a good response to past therapy, which was limited at best.

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

Sincerely,

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Daniel Y. Chin, for GP