

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 Health & Medical Practice Associates 3244 North 23 rd Street Ste 201 Beaumont, Texas 77707	MDR Tracking No.: M5-05-2087-01
	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		
07-01-04	08-04-04	97032, 97530, 97124-59, 97112-59, 97035, 97140-59, 97110, 97012-59 and 95904 (medical necessity issues)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
05-17-04	05-26-04	97032-GP (see specific dates below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
05-17-04	05-26-04	97035-GP (see specific dates below)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10-27-04	11-18-04	97032-GP (see specific dates below)	<input checked="" 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.

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. The electrical stimulation, therapeutic activities, massage therapy, neuromuscular re-education, ultrasound, manual therapy technique, therapeutic exercises, mechanical traction and nerve conduction testing-sensory nerve rendered on 07-01-04 through 08-04-04 **were not found** to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 04-27-05, 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 code 97032– GP dates of service 05-17-04, 05-19-04, 05-20-04, 05-24-04 and 05-26-04 (7 units total) denied with denial code “N” (not documented). The requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 97035-GP dates of service 05-17-04, 05-19-04, 05-20-04 and 05-26-04 (7 units total) denied with denial code “N” (not documented). The requestor did not submit documentation for review. No reimbursement is recommended.

CPT code 97032-GP dates of service 10-27-04, 10-28-04, 10-29-04, 11-01-04, 11-03-04, 11-04-04, 11-10-04, 11-11-04, 11-15-04, 11-17-04 and 11-18-04 (22 units) denied with denial code “F/713” (Fee schedule MAR reduction/charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has not made any payment. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$412.06 (\$14.98 X 125% = \$18.73 X 22 units)**.

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 reimbursement for fee issues involved in this dispute. The Medical Review Division has determined that the requestor is not entitled to reimbursement for the medical necessity issues or a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$412.06, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision and Order by:

Debra L. Hewitt

07-06-05

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 en 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 29, 2005

Re: IRO Case # M5-05-2087 -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, Rule 133.308 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. RME 1/25/05, Dr. Robinson
4. Peer reviews, CONSILIUMMD
5. Diagnostic test reports 5/19/04, 5/20/04, 5/24/04, 5/26/04
6. MRI report right knee 7/15/04

7. Office notes 5/14/04 and medical records 5/14/04 – 2/16/05, Dr. McMeans
8. Motor nerve velocity study reports 5/19/04, 5/20/04, 7/21/04, 7/22/04, 7/26/04
9. Sensory nerve study reports 5/24/04, 5/26/04, 7/28/04, 7/29/04, 8/2/04
10. FCE reports 5/11/04, 6/2/04, 8/4/04, 11/8/04
11. Operative report 8/25/04 and medical records 8/6/04, 8/20/04, Dr. Ghadially
12. Daily physical therapy notes 5/19/04 – 11/17/04
13. Progrss notes 5/14/04 – 12/3/04

History

The patient is a 64-year-old female who in ___ slipped and fell on a wet floor. She twisted her knee and hit her head on the floor. The patient presented with complaints of pain in the neck and right knee. X-rays in the neck and right knee were negative for fracture or dislocation. The patient was treated with physical therapy, which helped her neck. She continued to have knee pain. An MRI of the right knee on 7/15/04 demonstrated a grade III tear of the posterior horn of the medial meniscus. The patient was referred to an orthopedic surgeon and she eventually underwent arthroscopic meniscectomy and patellar chondroplasty on 8/25/04.

Requested Service(s)

Electrical stimulation (manual), therapeutic activities, massage therapy, neuromuscular re-education, ultrasound, manual therapy technique, therapeutic exercises, mechanical traction, nerve conduction testing – sensory nerve 7/1/04 – 8/4/04

Decision

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

Rationale

The patient continued to complain of severe pain in the right knee. There was evidence of meniscal pathology, as noted in the clinical notes, with postive McMurry signs. The patient previously had 21 sessions of physical therapy without documented improvement.

The patient's neck pain was described as very mild on her follow up visit on 6/16/04. At that point in her treatment there would be no need for continued supervised physical therapy for her neck. She could have continued a home exercise program on her own.

The physical therapy was not benefiting the patient's knee, and therefore there was no need to continue this treatment method.

The documentation for the requested nerve conduction testing – sensory nerve does not describe a sensory nerve conduction study as described by the coding. No latency amplitude nerve conduction study velocity was recorded. The records provided for review do not include a description of the procedure or documentation for its medical necessity.

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

Sincerely,

Daniel Y. Chin, for GP