

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 Dr. Suhail Al-Sahli 1210A NASA Road 1 Houston, Texas 77058	MDR Tracking No.: M5-05-2104-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company Box 54	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		
05-10-04	10-05-04	97110, 97124, 97035 and 97032	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
05-10-04	10-05-04	97140, 98940, 99212, 97012, 97112, 99213, 98941, 98943, 97116	<input type="checkbox"/> Yes <input checked="" 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 total due from the carrier in reimbursement for the medical necessity issues equals **\$2,707.42**.

Receipt of payment from the carrier for CPT code 97110 (2 units) and CPT code 97140 (1 unit) on date of service 05-10-04 was verified with the requestor, therefore these services are no longer in dispute and will not be a part of the review.

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 04-28-2005, 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 code 97012 date of service 08-05-04 and CPT code 97110 (2 units) date of service 09-01-04 revealed that neither party submitted a copy of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of the carrier's receipt of the providers request for EOBs. No reimbursement is recommended.

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 the services involved in this dispute totaling \$2,707.42 and is entitled to a refund of the paid IRO fee in the amount of \$650.00. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services 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:

07-27-05

Authorized Signature

Date of Decision

Order By:

07-27-05

Authorized Signature

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

July 19, 2005

Re: IRO Case # M5-05-2104 -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 Orthopedic Surgery 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. Reports from C.L.C., Dr Al Sahli
4. MRI report right shoulder 8/19/03
5. Report MRI cervical spine, 1/21/03
6. Reports, Dr. Elbaz

7. Operative report 3/2/04

8. Report 4/1/03, Dr. Vachhani
9. Designated doctor reports 10/4/04, 2/22/05 Dr. Smith

History

The patient injured his right shoulder and cervical spine in _____. The patient saw his D.C. on 12/7/02, and the D.C. recommended conservative treatment, including physical modalities and manipulation on his shoulder and neck. Because of persistent symptoms, MRIs of the shoulder and cervical spine were ordered. Abnormal findings on those tests led to orthopedic evaluation and injections. On 3/2/04 a surgical procedure was performed to the right shoulder, including arthroscopic subacromial decompression and SLAP repair.

Requested Service(s)

Office visit established patient, therapeutic exercises, neuromuscular re-education, gait training, manual therapy technique, chiropractic manipulation, massage therapy, ultrasound, mechanical traction, electrical stimulation 5/10/04 – 10/5/04

Decision

I disagree with the carrier's decision to deny the requested therapeutic exercises, massage, ultrasound and electrical stimulation 5/10/04 – 7/14/04. I agree with the decision to deny all of the other requested services.

Rationale

Post operatively the patient's surgeon kept the patient in a sling for four weeks. The patient saw his D.C. on 4/9/04, but apparently the physical therapy program was not started until 5/10/04. The therapy from 5/10/04 through 7/14/04 represents therapy that was delayed because of the time required to protect the SLAP repair. Approximately two months of therapy would be more than adequate to graduate the patient to a home exercise program. The documentation provided for this review was inadequate to support the necessity of gait training, neuromuscular reeducation, manual therapy, chiropractic manipulation and mechanical traction. Office visits would not be medically necessary during physical therapy visits.

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

Sincerely,

Daniel Y. Chin, for GP