

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 Neuromuscular Institute of Texas-PA 9502 Computer Drive, Suite 100 San Antonio, Texas 78229	MDR Tracking No.: M5-05-2248-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Box 42	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		
04-26-04	07-01-04	E0745 and 99213	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
06-03-04	07-01-04	L1906 and 97035	<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 **\$1,056.82**.

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 05-16-05, 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.

HCPCS code A4556 (electrodes) denied with denial code “G” (payment is denied because the charge was included in another billed procedure). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service HCPCS code A4556 was global to. Reimbursement is recommended in the amount of **\$50.00**.

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 totaling \$1,106.82 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 and Order By:

06-15-05

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 13, 2005

Re: IRO Case # M5-05-2248 -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 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. TWCC 69 7/25/04
4. D.D. report, 1/6/05, Dr. Bangole
5. Initial report 4/26/04
6. PME report 4/26/05
7. TWCC work status reports
8. Notes, Dr. Burdin
9. Daily treatment logs, N.I.T.
10. MRI report left ankle, 5/25/04
11. Radiology report left ankle, 4/27/04
12. Report, 6/3/04, Dr. Wilson
13. Exam reports, Dr. Wilson
14. Request for WC program, 7/23/04, N.I.T.
15. FCE reports, 7/6/04, 9/14/04
16. Notes WC program, N.I.T.
17. Treatment notes WC program, N.I.T.
18. PPE reports 5/4/04, 6/9/04

History

The patient injured his left ankle in ___ while he was pulling a fire hose across uneven ground. He was seen by his chiropractor, and was treated with orthotics, ankle brace, ultrasound, muscle stimulation, neuromuscular stimulator therapeutic exercises and medications. MRI and x-rays were obtained.

Requested Service(s)

Neuromuscular stimulator, office visit, left foot orthosis, ultrasound 4/26/04 – 7/1/04

Decision

I agree with the carrier's decision to deny the requested neuromuscular stimulator, foot orthosis, office visit (99213), all services after 5/26/04, and I disagree with the decision to deny the other requested services through 5/26/04.

Rationale

The D.C.'s treatment is well documented and supports much of his treatment. It was reported by an orthopedic surgeon on 6/3/04 that the patient had "numerous injuries to this" (left ankle), "but this time it was more swollen than the past." However, in the D.C.'s initial report on 4/26/04 it was noted that the patient denied any significant traumatic history or significant major history with respect to the left ankle.

Based on the records provided for this review, treatment failed to be of benefit to the patient, yet, for the most part, it was reasonable and necessary. The patient deserved an initial trial of conservative treatment, but after approximately four weeks of intensive treatment, there was still no documented relief of symptoms or improved function, and there was little, if any, benefit with treatment for the entire disputed time frame.

The neuromuscular stimulator was not warranted and would be excessive, as the patient was receiving similar treatment with the D.C. No documentation was provided to support the orthosis, or that showed it was beneficial. Further, it was noted that the patient could not adjust to the foot orthosis, and that they caused problems. An expanded problem-focused history and evaluation is not reasonable and necessary for a sprained ankle.

Sometimes in treatment of an injury, the doctor's intent is good, but doing too much to try to help a patient can be not helpful to the patient at all. Based on the records provided, the D.C. may have done too much, and after four weeks of intensive, failed treatment, the treatment plan should have been re-evaluated. Based on the records provided, the treatment plan apparently was not re-evaluated. Services after 5/26/04 were not reasonable and necessary as they failed to be of benefit to the patient (after four weeks of failed treatment), and they were excessive.

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

Sincerely,
Daniel Y. Chin, for GP