

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 Trinity Physical Medicine 2800 Brown Trail Bedford, TX 76021	MDR Tracking No.: M5-05-2279-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Atlantic Mutual Insurance Company, Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
4-21-04	5-13-04	CPT codes 97110, 97112, 97113, 97530, 97140, 99213, 99214	<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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues is \$536.09. (This total does not include separate reimbursement for code 97530 since it is global to 97140 which was also billed on this date of service. It does not include separate reimbursement for code 97113 since it is global to 97530. A modifier is allowed in order to differentiate between the services. The medical notes do not support separate payment for these services.)

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 5-17-05 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 97113-59 on 4-21-05 (4 units), 4-22-05 (4 units), 4-26-05 (4 units), 4-28-05 (4 units) and 4-29-05 (4 units) was denied as "G – Unbundling". Per the 2002 MFG CPT code 97113 is a CCI component procedure of CPT Code 97530 which

was billed on this date of service. A modifier is allowed in order to differentiate between the services. The medical notes do not support separate payment for these services. **Recommend no reimbursement.**

CPT code 97530-59 on 4-21-05, 4-22-05, 4-26-05, 4-28-05 and 4-29-05 was denied as "G – Unbundling". Per the 2002 MFG CPT code 97140 is a CCI Mutually Exclusive component procedure of CPT Code 97140 which was billed on this date of service. A modifier is allowed in order to differentiate between the services. The medical notes do not support separate payment for these services. **Recommend no reimbursement.**

CPT code 99213-25 on 4-21-04 and 4-26-04 was denied by the carrier as "F – Fee Guideline MAR reduction". The EOB reveals that an allowance was recommended by the carrier. A representative of the requestor states that no payment was received. **Recommend reimbursement per Commission Rule 133.1(a)(8) of \$113.92 (\$56.96 x 2 DOS).**

Regarding CPT code 97110 on 5-13-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's per rule 133.307(e)(3)(B). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

PART IV: COMMISSION DECISION AND ORDER

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 the amount of \$650.01, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Donna Auby	7-28-05
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

July 13, 2005

Re: IRO Case # M5-05-2279-01 ____

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. RME report 2/14/04, Dr. Doyne
4. Internal medicine consult evaluation 2/28/03, Dr. Waddle
5. Operative report 3/24/03, Dr. Myles
6. Report MRI cervical spine 10/19/04
7. Radiology report lumbar spine 7/1/03, 4/10/03
8. Examination / progress notes, Dr. Love
9. Examination notes, (physician's signature not legible)
10. Progress notes, Dr. Myles
11. Procedure notes, Dr. Stanton
12. Operative report 10/6/03, Dr. Stanton

History

The patient injured his lower back in ____ when he fell down stairs and landed on some pallets. He has had lower back surgery three times. He has also been treated with injections, medication, physical therapy and chiropractic treatment.

Requested Service(s)

Therapeutic exercises, neuromuscular reeducation, aquatic therapy, therapeutic activities, manual therapy technique, office visits
4/21/04 – 5/13/04

Decision

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

Rationale

The patient had undergone three lower back surgeries prior to seeing the treating D.C. without significant relief of his symptoms, and the patient was referred to the D.C. for treatment.

The D.C.'s treatment plan is appropriate and well-documented. There is documentation of counseling about obesity and losing weight. The patient reported that he continued to improve under the D.C.'s care, and that the therapy regimen was helping him significantly. Based on the records provided for review, the patient's treatment appeared to be producing measurable and objective improvement, as well as subjective relief of radicular symptoms, enabling the patient to work. Treatment was also provided in the least intensive, most cost-effective setting.

The D.C.'s treatment plan included a gradual movement toward a self-directed exercise program at a health club, which was successful. The D.C.'s notes indicate continuing improvement in objective measures for range of motion, strength and function, justifying therapy. If an individual's expected restoration potential is significant in relation to the extent and duration of therapy services required to achieve such potential, the services would be reasonable and necessary, and they are in this case.

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

Sincerely,

Daniel Y. Chin, for GP