

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 324 North 23 rd Street, Suite 201 Beaumont, Texas 77702	MDR Tracking No.: M5-05-2308-01
	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		
04-28-04	05-17-04	97530-GP, 97032-GP and 97035-GP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
06-15-04	06-17-04	97032-GP, 97035-GP, 97530-GP and 97110-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
06-18-04	06-18-04	97032-GP, 97035-GP and 97530-GP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
06-22-04	06-29-04	97032-GP, 97035-GP, and 97530-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
06-30-04	06-30-04	97032-GP, 97035-GP and 97530-GP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
07-02-04	07-14-04	97035-GP and 97530-GP	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
07-15-04	02-14-05	97530-GP, 97032-GP, 97035-GP and 97124-GP	<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 requestor withdrew CPT codes 97032, 97530 and 97110 for date of service 05-14-04, therefore, these dates will not be included in the review.

The Division has reviewed the enclosed IRO decision and determined that the requestor **did not** prevail on the **majority** of disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$1,033.63**.

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 05-23-05, 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.

Review of CPT code 97124-GP date of service 09-28-04 revealed that neither party submitted a copy of an EOB. Per Rule

133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$26.28 (\$21.02 X 125%)**.

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute totaling \$1,059.91 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:

Authorized Signature

8/12/05

Date of Decision and 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

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005, should be aware of changes to the appeals process which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH 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.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona en español acerca de esta 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

August 8, 2005

Re: IRO Case # M5-05-2308 -01 ____

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) by the Texas Department of Insurance and has been authorized to perform independent reviews of medical necessity for Texas Worker's Compensation cases. 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 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. Daily notes 4/28/04 2/14/05, Dr. Novelli
4. Medical progress notes 4/21/04 – 2/24/05
5. Physical therapy consult report 4/21/04
6. FCE reports 2/18/04, 12/5/03
7. Note 8/26/04, Dr. Corley
8. Medical records 2/10/04 – 1/5/05, Dr. Rubin
9. Reports MRI right knee, 5/28/03, 1/7/04
10. Report x-ray right knee 1/7/04
11. Operative reports 9/10/03, 2/24/04, 11/18/04
12. Medical records 6/13/03 – 10/28/03, Dr. Fleming

History

The patient is a 48-year-old male who in ___ slipped off a trailer, landing on his right knee. A 5/28/03 MRI showed findings suspicious for a partial tear of the ACL and a complex tear of the posterior horn of the medial meniscus. On 9/10/03 the patient underwent arthroscopy with subtotal medial meniscectomy and plica resection. His post-operative course was unremarkable. A 12/5/03 FCE indicated that the patient was able to work at a heavy physical demand level. It also indicated that the patient continued to complain of instability in his knee. At the time of the 9/10/03 surgery, the ACL was not repaired. The patient then began treatment with another physician, who sent the patient for orthopedic evaluation. On 3/28/04, the patient underwent arthroscopic ACL reconstruction, bilateral meniscectomy, medial and lateral femoral tibial chondral arthroplasty, and insertion of a pain pump catheter. The patient began physical therapy on 4/28/04, but he continued to have pain and irritation as a result of the hardware. On 11/8/04 he underwent right knee removal of hardware.

Requested Service(s)

Therapeutic activities, elec stimulation, ultrasound, therapeutic exercises, massage therapy
4/28/04 - 2/14/05

Decision

I agree in part and disagree in part with the carrier's decision to deny the requested services.

Rationale

I agree with the denial of the requested services 4/28/04 – 5/17/04. Physical therapy following ACL reconstruction is medically necessary and appropriate. Standards and guidelines for those physical therapy sessions limit sessions to 45 minutes per session, three times per week on non-consecutive days. Therapy should consist primarily of active therapeutic exercises. These disputed services exceed those limitations by either extending the therapy sessions beyond the 45 minutes allowed, or occurring on consecutive days.

I disagree with the denial of therapeutic activities (97530) on 6/15/04, 6/17/04, 6/22/04, 6/25/04, 6/29/04, 7/2/04, 7/7/04, 7/9/04, and 7/14/04. It is the standard of care and medically necessary for the patient to undergo physical therapy for up to 12 weeks following ACL reconstruction surgery. Although there is an unexplained gap in the therapy treatment between 5/17/04 and 6/15/04, these sessions fall within that accepted timeframe. Medical necessity for therapy beyond the 12 weeks must be documented and therapeutic exercises should be the dominant therapy.

I disagree with the denial of electrical stimulation 6/17/04 and 6/22/04. These treatment modalities are a good adjunct to therapeutic exercises for the first eight weeks of post ACL reconstruction therapy. They also fall within the 45-minute timeframe that is allowed.

I agree with the denial of modalities on 7/16/04 and 7/20/04. Modalities were only used on these two dates. There is no documented medical necessity for modality only physical therapy this far out from surgery. Therapy should consist predominantly of therapeutic active exercises.

I agree with the denial of services on 6/18/04, 6/30/04 and 7/15/04. Physical therapy treatment should occur no more than three times per week on non-consecutive days. Anything more than that would not be medically necessary and appropriate.

I agree with the denial of services 9/21/04 forward. At this point in the patient's recovery, he could have been discharged to a home exercise program.

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

Sincerely,

Daniel Y. Chin, for GP