

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Anthony Jones, D.C. 201 East Main Street Richardson, Texas 75080	MDR Tracking No.: M5-05-2356-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Box 28	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		
05-04-04	12-15-04	98940, 98941, 97140, 97124, 99201, 99213, 97139, 97032 and 97112	<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 not** prevail on the disputed medical necessity issues.

Dates of service 04-12-04 through 04-30-04 were not timely filed per Rule 133.308(e)(1) therefore 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 06-16-05, 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.

CPT code 97124 date of service 05-19-04 denied with denial code "G" (global). Per the 2002 Medical Fee Schedule code 97124 is global to CPT code 97140 billed on the same date of service. No reimbursement is recommended.

CPT code 99201 dates of service 05-19-04, 05-24-04, 05-28-04, 06-04-04 and 08-11-04 are listed on the table of disputed services. Explanation of benefits submitted by the carrier indicate reimbursement per the 2002 Medical Fee Schedule for all

dates of service. The requestor's office was contacted to verify payment, however, no response has been received. No additional reimbursement is recommended.

CPT code 97140 dates of service 05-19-04, 05-28-04, 06-04-04 and 08-11-04 are listed on the table of disputed services. Explanation of benefits submitted by the carrier indicate reimbursement per the 2002 Medical Fee Schedule for all dates of service. The requestor's office was contacted to verify payment, however, no response has been received. No additional reimbursement is recommended.

CPT code 97139 dates of service 05-19-04, 05-28-04, 06-04-04 and 08-11-04 are listed on the table of disputed services. Explanation of benefits submitted by the carrier indicate reimbursement per the 2002 Medical Fee Schedule for all dates of service. The requestor's office was contacted to verify payment, however, no response has been received. No additional reimbursement is recommended.

CPT code 97124 date of service 05-24-04 and CPT code 97032 date of service 08-11-04 are listed on the table of disputed services. Explanation of benefits submitted by the carrier indicate reimbursement per the 2002 Medical Fee Schedule for the dates of service in dispute. The requestor's office was contacted to verify payment, however, no response has been received. No additional reimbursement is recommended.

Review of CPT codes 99201, 97032, 97139 and 97140 dates of service 07-28-04, 07-30-04, 10-08-04, 10-25-04, 11-22-04, 12-01-04, 12-06-04, 12-13-04 and 12-15-04 as well as code 99213 dates of service 08-02-04, 11-22-04 and 12-06-04 revealed that neither party submitted copies of EOBs. These dates of service are dismissed and will not be a part of the review.

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 reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

08-31-05

Authorized Signature

Date of Decision

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 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

August 1, 2005

Re: IRO Case # M5-05-2356 -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, 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. Letter to IRO from carrier 7/1/05
4. Reports, 10/11/04, 4/3/03, Dr. Harvey
5. Reviews, Professional Reviews Inc.
6. Peer review 4/3/04, Dr. K
7. IR evaluation 3/18/05, Dr. Guerrero
8. Reports 6/9/04, 6/1/04, Dr. Mackenzie
9. MRI report lumbar spine 3/13/03
10. Report 5/21/04, Dr. Chouteau
11. Report 5/15/03, Dr. Nosnik
12. FAE 4/3/03
13. Response letters 2/27/04, 8/2/04, Dr. Jones
14. Notes, Dr. Jones
15. Notes, Dr. Shah
16. CT lumbar spine report 1/15/04
17. Treatment notes, 1st Aid Accident Injury Pain Center
18. TWCC work status reports

History

The patient injured his lower back in ___ while he was grinding a piece of metal and was pulled towards the machine. A CT scan and MRI were obtained. The patient has been treated with medication, injections, chiropractic care and physical therapy.

Requested Service(s)

Chiropractic manipulative treatment, manual therapy technique, massage therapy, office visits, unlisted therapeutic procedure, electrical stimulation (manual), neuromuscular re-education 5/4/04 – 12/10/04

Decision

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

Rationale

The patient received an adequate trial of conservative care prior to the dates in this dispute with poor results. Based on the MRI findings, the prognosis for successful conservative therapy would be very poor. ESIs and TPIs failed to be of any benefit, and actually increased the patient's pain. On 10/11/04, after several months of intense treatment, it was reported that the patient's VAS was 8/10, that increased with bowel movements, bending, standing and walking. It was also noted that the patient continued to receive physical therapy and chiropractic therapy without improvement.

The treating D.C.'s notes do not show subjective or objective relief of symptoms, or improved function.

The failure of continued therapy does not establish a medical rationale for additional non-effective therapy.

The D.C.'s notes do not indicate that the patient received any lasting objective benefit or improvement in objective measures of range of motion, strength or function that would justify therapy. Treatment had failed to return the patient to work. As therapy progresses, there should be a decrease in the frequency and intensity of therapy, and a gradual transition to a home program. This progress and transition was not evident in the D.C.'s notes. In the absence of continuing objective and subjective benefit, the medical necessity of the treatment was not established.

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

Sincerely,

Daniel Y. Chin, for GP