

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 David M. Griffith, D.C. 30525 Quinn Road # A Tomball, Texas 77375	MDR Tracking No.: M5-05-2392-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Home Assurance Company Box 19	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		
08-23-04	11-01-04	97110, 99354, 99214, 99213, 97112, 97140, 97035 and 99212	<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.

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 06-07-2005, 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.

CPT code 97112 (18 units) dates of service 08-23-04, 08-25-04, 08-27-04, 08-30-04, 09-01-04, 09-07-04, 09-08-04, 09-10-04, 09-13-04, 09-17-04, 09-21-04, 09-22-04, 10-01-04, 10-04-04, 10-11-04, 10-13-04, 10-22-04 and 10-29-04 denied with denial code "F/713" (Fee Schedule MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made no payment. Per the 2002 Medical Fee Guideline reimbursement is recommended in the amount of **\$617.40 (\$34.30 billed by requestor X 18 units)**.

CPT code 97032 (16 units) dates of service 08-23-04, 08-25-04, 08-27-04, 08-30-04, 09-01-04, 09-07-04, 09-08-04, 09-10-04, 09-13-04, 09-17-04, 09-21-04, 09-22-04, 10-01-04, 10-04-04, 10-11-04 and 10-13-04 denied with denial code "F/713" (Fee Schedule MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear

reasonable). The carrier has made no payment. Per the 2002 Medical Fee Guideline reimbursement is recommended in the amount of **\$299.52 (\$18.72 billed by requestor X 16 units)**.

CPT code 97035 (16 units) dates of service 08-23-04, 08-25-04, 08-27-04, 08-30-04, 09-01-04, 09-07-04, 09-08-04, 09-10-04, 09-13-04, 09-17-04, 09-21-04, 09-22-04, 10-01-04, 10-04-04, 10-11-04 and 10-13-04 denied with denial code "F/713" (Fee Schedule MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made no payment. Per the 2002 Medical Fee Guideline reimbursement is recommended in the amount of \$236.96 (\$14.81 billed by requestor X 16 units).

CPT code 97110 (22 units) dates of service 09-13-04, 09-17-04, 09-21-04, 09-22-04, 10-01-04, 10-04-04, 10-11-04, 10-13-04, 10-22-04 and 10-29-04 denied with denial code "F/713" (Fee Schedule MAR reduction/the charge exceeds the scheduled value and/or parameters that would appear reasonable). The carrier has made no payment. 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 of all of the Commission requirements for proper documentation. 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 services involved in this dispute totaling \$1,153.88 and is **not** entitled to a refund of the paid IRO fee. 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 and Order by:

Authorized Signature

07-28-05

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

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 21, 2005

Re: IRO Case # M5-05-2392 –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, 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 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. Summary for IRO 12/13/03
4. Reviews, Consilium MD
5. IME 3/24/04, Dr. Kennedy
6. Request for MDR 3/8/05
7. Initial evaluation 8/20/04, Dr. Griffith
8. Progress notes and treatment notes, Dr. Griffith
9. Follow up evaluations, Dr. Griffith
10. Lumbar spine rehab logs, Dr. Griffith
11. Work hardening/work conditioning notes
12. Reports, Wilford Hall Medical Center
13. Physical therapy notes, Wilford Hall Medical Center
14. Examination and treatment notes, Wilford Hall Medical Center
15. Employer's first report of injury
16. Reports, Peterson Memorial Hospital
17. TWCC work status reports
18. MRI report lumbar spine 3/16/04
19. FAE report 3/24/04
20. Electrodiagnostic study 8/27/04
21. Pain management consultation report 8/31/04, Dr. Krucyk
22. Pain management follow up reports, SADI
23. FCE /PPE reports 10/26/04, 12/14/04

- 24. Psychiatric evaluation 10/28/04
- 25. Report 3/30/05, Dr. Gutzman
- 26. MMI / IR report 4/18/05, Dr. Outlaw

History

The patient injured his lower back in ___ when a pallet carrying heavy equipment shifted and pinned him against a truck. He saw one D.C. for treatment, then moved and began treatment with the treating D.C. on 8/20/04. MRI and EMG evaluation have been performed. The patient has been treated with medication, epidural steroid injections, physical therapy and chiropractic treatment.

Requested Service(s)

Therapeutic exercises, prolonged physical srvc, OV (99212, 99213, 99214), neuromuscular re-education, manual therapy technique, ultrasound 8/23/04 – 11/1/04

Decision

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

Rationale

The records provided for this review do not indicate that the treatment cured or relieved the effects of the injury, promoted recovery, or helped to return the patient to work. If an individual's expected restoration potential is insignificant in relation to the extent and duration of services required to achieve such potential, the services are not reasonable and necessary.

On 2/22/05, after around six months of active treatment from the D.C., the patient's VAS was 8/10, and the records fail to show any functional improvement related to strength gains or range of motion. There is no indication in the notes that the patient continued to receive any significant, lasting, objective or subjective benefit. Overall, there was no discernable rationale for the continuation of treatment, or indication of benefits obtained.

The patient responded poorly to the D.C.'s care, and epidural steroid injections were necessary, which also were not of benefit. Given the MRI findings, showing advanced multi-level disk degeneration and facet joint degeneration, the prognosis would be poor, at best, for successful conservative treatment.

Based on the records provided for this review, the patient's condition plateaued in a diminished state prior to the D.C.'s treatment. The patient had an adequate trial of care that failed to be of benefit. There was no objective evidence to support the treatment in this dispute as beneficial. The medical necessity for the type of care rendered at the stage of treatment during the period in this dispute was not identified.

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

Sincerely,

Daniel Y. Chin, for GP