

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## Retrospective Medical Necessity Dispute

### PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (X) HCP ( ) IE ( ) IC	<b>Response Timely Filed?</b> ( ) Yes (X) No
Requestor's Name and Address Bradley E. Brown, D.C. P O BOX 1447 Red Oak, Texas 75154	MDR Tracking No.: M5-05-2408-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Ace American Insurance Company Box 15	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		
10-01-04	11-12-04	98940, 98943-51, 97140-59 and 97012	<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 **did** prevail on the disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$1,284.87**.

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 06-23-05, 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.

CPT code 99080-73 date of service 10-01-04 denied with denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$15.00**. A Compliance & Practices referral will be made as the carrier is in violation of Rule 129.5.

### 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 the services involved in this dispute totaling 1,299.87 and 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 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 # M5-05-2408 –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. Review, 2/6/05, Dr. Tran
4. IME report 9/15/04, Dr. Shade
5. Reports 9/04 – 6/05, Dr. Levy
6. TWCC work status reports
7. Letter to IRO 6/23/05, Dr. Brown
8. Request for reconsideration 3/26/05, Dr. Brown
9. Treatment notes, Dr. Brown
10. Report 12/28/04, Dr. Overman
11. Report 11/5/04, Dr. Milani
12. Cervical myelogram report 11/29/04
13. MRI cervical spine report 6/15/05
14. EMG/NCS report 6/4/04, Dr. Morrison

### History

The patient injured her left shoulder in \_\_\_\_ when she was lifting heavy boxes overhead. The patient has been evaluated with MRI, EMG, and myelogram. She has been treated with injections, medication and surgery.

### Requested Service(s)

Chiropractic manipulative therapy, manual therapy technique, mechanical traction 10/1/04 – 11/12/04

### Decision

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

### Rationale

According to the records provided for this review, the patient responded well to treatment from the treating D.C. In a 9/15/04 report, an orthopedic surgeon recommended continued physical therapy at a frequency of two times per week for four more weeks. In a 10/10/04 report a physical medicine specialist recommended continued conservative therapy, stating that the patient had demonstrated symptomatic improvement. In his report on 10/22/04, the patient's orthopedic surgeon stated that the patient "has made tremendous improvement since her last visit" on 10/8/04. The report further noted that the patient's ROM was excellent, and that strength had markedly improved, and that treatment should be continued.

The patient has had reasonable and necessary work ups and non operative treatment for the left shoulder and cervical spine. The D.C.'s treatment notes showed objective, quantifiable findings to support treatment for the dates in this dispute. The patient's expected restoration potential was significant in relation to the extent and duration of the D.C.'s services required to achieve the potential. The D.C.'s records document the plan of care and reasoning to continue therapy. The records also showed continuing significant benefit, even though surgery was eventually necessary.

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

Sincerely,

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Daniel Y. Chin, for GP