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 Cotton D. Merritt, D.C. 2005 Broadway Lubbock, Texas 79401	MDR Tracking No.: M5-05-2497-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Federated Mutual Insurance Company Box 01	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**		
10-28-04	**12-17-04**	**99212-25**	☐ **Yes** ☒ **No**
10-28-04	**11-10-04**	**97110, 97112, 97140**	☒ **Yes** ☐ **No**
11-12-04	**11-24-04**	**97110, 97112 and 97140**	☐ **Yes** ☒ **No**
11-24-04	**11-24-04**	**97110, 97112 and 97140**	☒ **Yes** ☐ **No**
11-29-04	**11-29-04**	**97110, 97112 and 97140**	☐ **Yes** ☒ **No**
12-01-04	**12-01-04**	**97119, 97112 and 97140**	☒ **Yes** ☐ **No**
12-03-04	**12-17-04**	**97110, 97112 and 97140**	☐ **Yes** ☒ **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 **majority** of the disputed medical necessity issues. The amount of reimbursement due from the carrier for the medical necessity issues equals **$1,814.06.**

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 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 $1,814.06 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:

		08-12-05
Authorized Signature		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 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 9, 2005
Re: IRO Case # M5-05-2497 –01 ___ amended 8/10/05

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 Neurological Surgery, 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. Operative reports 8/10/04, 2/12/04
4. Notes 2003 – 2005, Dr. Merritt
5. Lumbar MRI reports 6/14/04, 12/29/03
6. Lumbar CT myelogram report 9/13/03
7. Reports 2004 –2005, Dr. Telfeian
8. Reports, Dr. Pracyk
9. Report 1/10/05, Dr. Johnson

History

The patient is a 41-year-old male who in ___ fell, striking his low back on a bar. He had immediate severe back pain, and this continued despite physical therapy. An 11/12/02 MRI showed an L4-5 disk herniation and significant bulging at L3-4 and L5-S1. Chiropractic treatment and injections were not successful in dealing with the patient's trouble, and on 2/12/04 a lumbar diskectomy at L4-5 was carried out. This was not significantly helpful, and despite physical therapy and epidural steroid injections, the trouble continued. On 8/10/04 a posterior lumbar interbody fusion with laminectomy at the L3-4, L4-5 and L5-S1 levels was carried out. There was some posterior migration of fusion material at L5-S1, but this became stable and did not present problems. The patient received considerable physical therapy,including exercises, neuromuscular re-education, and manual therapeutic measures. On 1/18/05 the patient's last surgeon indicated that he could return to work without restrictions. The patient continued to work until March 2005 when spasms in his back led to difficulties on his job as a security officer, and he was relieved of his duties.

Requested Service(s)

Office visits, therapeutic exercises, neuromuscular reeducation, manual therapy techniques 10/28/04 – 12/17/04

Decision

I agree in part and disagree in part with the carrier's decision to deny the requested services. I agree with the decision to deny the requested office visits. I disagree with the denial of services other than office visits 10/28/04 through 11/10/04. I disagree with the denial of services other than office visits on 10/17/04, 11/24/04, 12/1/04. I agree with the denial of the other requested services through 12/13/04.

Rationale

The patient had undergone extensive physical therapy prior to surgery. Physical therapy after the patient's surgery was medically necessary and appropriate, and it was helpful in enabling the patient to return to work. Based on the records provided for this review, however, the extent of the services provided was beyond what would be medically necessary. I agree with Dr. Johnson in his 1/10/05 review of the problem. After the initial six sessions with supervision, the patient's supervised therapy could have been reduced to one visit every week , then every two weeks, and the patient should have been transitioned to a home exercise program with instructions regarding home use of ice and heat.
Office visits would not be medically necessary during physical therapy sessions.

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

Sincerely,

_____

Daniel Y. Chin, for GP