

## 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  Carl M. Naehritz III, D. C. 2900 Hwy 121, Suite 120 Bedford, TX 76021	MDR Tracking No.: M5-05-2545-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address  Sentry Insurance A Mutual Company, Box 42	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

#### PART II: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ITEMS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
2-16-05	3-23-05	CPT codes 99213, 99215, 97140, 97530, 97110, 97112, 95831, E0900, 98926, 99358-22, 76800-TC, 76856-TC, 76880-TC, 99080	<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 **prevailed** on the disputed medical necessity issues. The amount due from the carrier for the medical necessity issues equals \$4,447.85. (This total does not include separate reimbursement for code 97530 since it is global to 97140. A modifier is allowed in order to differentiate between the services provided. No modifier was present on the HCFA. This total does not include separate reimbursement for code 95851 since it is global to 97140 and 99213. This total does not include separate reimbursement for code 99358-22. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Per Rule 134.202 (c)(6) "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

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.

On 6-22-05 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.

Regarding CPT code 99080-73 on 2-23-05: The carrier denied CPT Code 99080-73 with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter; **Recommend reimbursement of \$15.00.**

The requestor will be billed for inappropriate use of modifiers per Rules 134.202(6) and 134.202(e)(9).

**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 entitled to a refund of the paid IRO fee in the amount of \$460.00. The Division hereby **ORDERS** the insurance carrier to remit the amount of \$4,462.85, plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Findings and Decision by:

7-29-05

Ordered by:

7-29-05

Authorized Signature

Typed Name

Date of 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 22, 2005

**Re: IRO Case # M5-05-2545 -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. RME report 5/12/05, Dr. Perry
4. Review 2/20/05, Dr. Obermiller
5. DD evaluation 10/13/04, Dr. Marshall
6. EMG/NCV report 10/18/04
7. TWCC 69 and work status reports

8. Reports 3/4/05, 2/28/05, Dr. Banta
9. Notes, Dr. Van Hal
10. Physical therapy notes
11. FCE report 8/17/04
12. Ultrasound report 3/4/05
13. Treatment notes, Dr. Naehritz
14. Prescription for inversion table
15. Rebuttals to reviews, 3/16/05, 2/20/05
16. MRI report lumbar spine 7/16/04
17. Notes and x-ray reports, Parkview Hospital

#### History

The patient injured his lower back in \_\_\_\_ when he pulled on a drill press machine and felt severe lower back pain. Numerous medical evaluations, x-rays, MRI and EMG have been performed. The patient has been treated with injections, medications, physical therapy and chiropractic care.

#### Requested Service(s)

Office visits, manual therapy technique, therapeutic activities, therapeutic exercises, neuromuscular reed, ROM, DME (traction stand pelvic), osteopathic manipulation, prolonged evaluation, ultrasound exam spinal canal, US exam pelvic complete, US exam extremity, special report 2/16/05 – 3/23/05

#### Decision

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

#### Rationale

The patient suffered an injury in \_\_\_\_\_. He received a few sessions of physical therapy, and then discontinued care. He later sought treatment from the treating D.C. on 1/25/05. Injections and medication had failed to give the patient any relief. An intensive course of conservative therapy had not been followed through with prior to the D.C.'s treatment in 2005, and an intensive trial of treatment was appropriate.

The patient's VAS for pain decreased from 10 to 4 under the D.C.'s care, and although relief was not permanent, it was beneficial. Treatment was based on documented objective, quantifiable findings. A pain management specialist also recommended continued conservative treatment on 3/4/05. The ultrasounds were reasonable and necessary in that they ruled out hematomas and tears, and they revealed paraspinous muscle spasms. The records provided indicate that the treatment was reasonable with the goal of helping the patient and progressing to a home exercise program. The DME was reasonable for progression in such a home-based 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