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 Buena Vista Workskills 5445 La Sierra Drive # 204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2589-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Argonaut Insurance Company Box 17	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**		
08-11-04	**09-17-04**	**97545-WH-CA and 97546-WH-CA**	☐ **Yes** ☒ **No**
07-29-04	**07-29-04**	**90801**	☐ **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 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 07-27-05, 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 90801 (5 units) date of service 07-29-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has made a payment of $193.40. No additional reimbursement is recommended as code 90801 is not a timed code per Medicare.

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:

		08-10-05
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

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 25, 2005

Re: IRO Case # M5-05-2589 –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. Report 11/17/05, Dr. Whitsell
4. Daily notes and examinations, Dr. Gonzales
5. MRI lumbar and cervical spine reports 4/26/04
6. TWCC work status reports
7. Pain management notes, Dr. Krucyek
8. FCE reports 7/26/04, 9/17/04
9. Behavioral consultation report 7/29/04
10. WC / WH notes and treatment logs

History

The patient injured her lower back and neck in ___ when she slipped and fell. MRIs were obtained of the lumbar and cervical spine. The patient has been treated with chiropractic care, medication and a WH / WC program

Requested Service(s)

Work hardening program 7/29/04 – 9/17/04

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 WH / WC program. In her initial WH / WC consultation on 7/29/04, the patient reported a VAS of 8-10 and that was "suffering from severe pain all the time." She was depressed, tired, numb in parts of her body, couldn't sleep and was unable to carry on with normal activities of daily living. The patient was unable to return to work.

These were signs that conservative treatment had failed to be beneficial to the patient. Given the patient's limited response to previous supervised therapy, a WH / WC program would not be medically indicated. The need for such a program is usually based on a good response to past treatment.

Based on the documentation provided for this review, there may have been some symptom magnification, and a lack of patient compliance with the WH / WC program. The patient frequently had to leave the treatment program to pick up her children, rarely finishing the WH / WC sessions. Usually a patient will exhibit a gradual improvement or worsening of symptoms with treatment, but this patient expressed drastic changes from treatment to treatment, without reason or evidence to support the claims. The patient's subjective complaints did not correspond to objective findings. It was frequently noted that the patient's symptoms fluctuated throughout the therapy sessions. Based on the records provided, it would have been appropriate to release the patient to a home-based exercise program and OTC medications prior to the WH / WC 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