Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor=s Name and Address: I	MDR Tracking No.: M5-05-2691-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: TML Intergovernmental Risk Pool Box 19	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 package, CMS 1500s, medical documentation and explanations of benefits

POSITION SUMMARY: Texas municipal League-IRP Insurance Company has denied payment after reconsideration was submitted. In summary, it is our position that Texas Municipal League has established an unfair and unreasonable decision for denial of payment for the services that were rendered to Mr. Brown.

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: No response was received from the Respondent.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
06-14-04 to 10-05-04	Work hardening, preparation of report and hypnotherapy	☐ Yes ☒ No	$0.00

PART V: 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 Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution 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 Medical Dispute Resolution.

On 06-14-05, 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 90806 dates of service 07-09-04, 07-27-04, 08-06-04 and 08-25-04 were denied with denial code "V" (unnecessary treatment-with peer review). These services were preauthorized with preauthorization request # 79513776. Reimbursement is recommended in the amount of **$472.00 ($118.00 X 4 DOS).** A Compliance and Practices referral will be made as the carrier is in violation of Rule 134.600(b)(B).

CPT code 90901 dates of service 08-06-04, 08-25-04 and 10-05-04 denied with denial code "V" (unnecessary treatment-with peer review). These services were preauthorized with preauthorization request # 79513776. The carrier made a payment of $47.23 on date of service 10-05-04. Reimbursement is recommended in the amount of **$94.46 ($47.23 X 2 DOS). NOTE:** Per the CPT Assistant, June 1999, Volume 9, Issue 6, page 7, 90901 should be used once to identify all modalities of biofeedback training performed for that date of service, regardless of time increments and number of modalities performed.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1) and 134.600(b)(B)
CPT Assistant, June 1999, Volume 9, Issue 6, page 7

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of $566.46.

The Division finds that the requestor was not the prevailing party and is not entitled to a refund of the IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30 days of receipt of this Order.

Ordered by:

		11-17-05
Authorized Signature		Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and 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. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en 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

November 1, 2005

Re: IRO Case # M5-05-2691 –01 _____ amended 11/8/05

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 Division of Workers' 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 cases be assigned to certified IROs, this case was assigned 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 Division of Workers' Compensation 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. Notice of IR decision, 9/22/05
4. Case review for injury, 10/5/05
5. Request for reconsideration 1/10/05
6. WH notes after 6/14/04
7. Initial FCE 2/9/04
8. Initial clinical review 1/6/04
9. Chronic pain management notes
10. WH/WC notes prior to the dates in dispute

History

The patient was injured in November 2003 when his bus was rear-ended by another vehicle. The patient was treated with chiropractic treatment, medication and a work hardening / conditioning program. An MRI was also obtained.

Requested Service(s)

Work hardening program, preparation of report, hypnotherapy 6/14/04 – 10/5/04

Decision

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

Rationale

The first W/C daily note reviewed (4/26/04) states that the patient, "completed the majority of his exercises today on his first day back after having completed his Work Conditioning Program." Therefore, it appears that the patient had chiropractic treatment, then a W/C program prior to the services in this dispute. However, no notes were provided for any services prior to 4/26/04 concerning a W/C program. The patient's pain level on 4/26/04 was 3/10.

P. Bohart's request for behavioral treatment dated 4/26/04 states that the patient had attended a W/C program for several

weeks and “made little in the way of functional progress.” It further states that the patient’s mood had continued to steadily decline and that “because of his continued active symptoms” further W/C was recommended.

It appears from the records provided that all treatment prior to the dates in this dispute had failed. The continued use of failed therapy does not establish a medical rationale for additional non-effective therapy. There is no indication in the W/C notes provided that there was any improvement in pain level, depression, anxiety or function. On 5/3/04 it was noted that the patient made little effort to participate in the exercises, and often tried to gain the attention of other patients by making loud exhaling noises. It was also noted many times that the patient received continuing phone calls that interrupted the exercise sessions. Though this was addressed, the cell phone calls persisted. It was noted that the patient did not like the clinic rules and indicated that he did not know if he would continue his treatment.

On 5/6/04 it was noted that “low back pain remains persistent in spite of different types of therapy,” and that “mental anxiety and depression continues to be intense,” and that the “patient is not coping effectively.” The patient’s pain level on 4/26/04 was 3/10, and on 5/25/04, it was still 3/10. It was noted that “he self-limited his leg press, calf press, leg ext, and neck stretch due to LBP’ due to spasm associated with increased lumbar spine lordosis. On 6/4/04 his pain level was noted as 5/10 due to tight lumbar spine and quads/hip flexors and weak abdominals and hamstrings. These are all examples of continuing treatment failing to be of any benefit to the patient. This was after some seven months of intense conservative therapy.

There is no indication in any of the documentation of any improvement in function, pain levels, or behavioral health. If an individual’s expected restoration potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, the services would not be considered to be reasonable or necessary. There is no identifiable reason in the records provided for this review why treatment after 4/26/04 was required for this patient. The records fail to show any change in subjective pain levels, no change is assessment of patient progress, and no change in treatment plan.

This medical necessity decision by an Independent Review Organization is deemed to be a Workers’ Compensation Division decision and order.

Sincerely,_____
Daniel Y. Chin, for GP