

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP () IE () IC	Response Timely Filed? () Yes (X) No
Requestor's Name and Address Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231	MDR Tracking No.: M5-05-2692-01
	TWCC 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: SUMMARY OF DISPUTE AND FINDINGS – MEDICAL NECESSITY ISSUES

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	To		
2-9-04	6-25-04	97545-WHCA, 97546-WHCA, 90806, 90889	<input type="checkbox"/> Yes <input checked="" 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 **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. The services, rendered were found were not found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-29-05 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 97750-FC (20 units) on 2-9-04 was denied as "No documentation to support services and total time." The requestor provided documentation to support delivery of services of only 15 units per Rule 133.307(g)(3)(A-F). **Recommend additional reimbursement according to the 2002 MFG of \$336.00 (\$514.50 MAR minus \$178.50 which was already paid by the carrier).**

CPT code 97546- WHCA on 3-15-04, 3-16-04 and 3-17-04 was denied as "940 – Re-evaluation, no additional payment recommended." The requestor provided documentation to support delivery of services per Rule 133.307(g)(3)(A-F). Neither party provided original EOB's. Reimbursement at the CARF rate is according to 134.202 (e)(5)(C)(ii) at \$64 per hour. **Recommend reimbursement of \$192.00 (\$64.00 X 3 DOS).**

CPT code 90901 on 5-6-04 was denied as "Re-evaluation – no additional payment recommended." In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Neither party provided original EOB's. According to the 2002 MFG and Medicare/AMA this is not a timed code. One unit equals one session. **Recommend reimbursement of \$47.23.**

CPT code 90889 on 5-6-04 was denied as "G-Unbundling". Per the 2002 MFG this is a bundled code. **Recommend no reimbursement.**

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 a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit the appropriate amount for the services in dispute consistent with the applicable fee guidelines totaling \$575.23, 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:

	Donna Auby	8-2-05
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

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
Fax 512/491-5145

Phone 512/248-9020
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 22, 2005

Re: IRO Case # M5-05-2692 –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. MRI report lumbar spine 1/21/04
4. MRI report cervical spine 1/20/04
5. Request for behavioral health treatment plan 5/28/04, 4/26/04, 8/4/04
6. Initial FCE 2/9/04
7. Treatment plan and goals 2/9/04, 5/18/04
8. PT reevaluation 3/15/04
9. Reevaluation FCE 11/19/04
10. Work conditioning daily notes
11. Pain management group notes
12. Biofeedback PPA notes

History

The patient injured his neck and lower back in a ____ motor vehicle accident in which he was rear-ended. He has undergone chiropractic treatment, and a work hardening/conditioning program.

Requested Service(s)

Work hardening program, psychotherapy, preparation of report of psychological status 2/9/04 – 6/25/04

Decision

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

Rationale

The patient underwent a course of chiropractic treatment prior to the WH / WC program. D.C. records were not provided for this review, but in order for a patient to enter a multi disciplinary program, a patient should have a satisfactory response to conservative treatment, with a goal of returning to work.

Careful review of the WH / WC records provided for this review revealed little, if any, functional progress. The records indicate that the patient's mood steadily declined during the period of the program. It was noted several times that the patient "bracing and guarding from pain," and that the "patient is not coping effectively." For medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. There is no indication in the notes provided for this review that the patient received any significant, lasting, objective or subjective benefit. There is no documentation of any continuing improvement in any objective measures for range of motion, strength or function that would justify the WH / WC program. Even subjective complaints did not appear to be appreciably affected, despite continuing treatment.

No documentation was provided that demonstrated any significant, continuing benefit, as a result of the services received. In the absence of documented, significant pathology or continuing, objective benefit, the medical necessity of the services in this dispute has not been established.

The records provided did not validate functional improvement, progression of the rehabilitation program, or a move towards self directed care. Based in the records provided, treatment appears to have been excessive.

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

Sincerely,

Daniel Y. Chin, for GP