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: Southeast Health Services, Inc. P O BOX 170336 Dallas, Texas 75217	MDR Tracking No.: M5-06-0078-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Indemnity Insurance Company Box 15	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: DWC-60 dispute package
POSITION SUMMARY: Per the table of disputed services "Please see the attached documentation marked Exhibit 4 for clarification of the services rendered to this patient".

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

DOCUMENTATION SUBMITTED: Response to DWC-60
POSITION SUMMARY: The Respondent requests that a Findings and Decision be entered finding that no additional payment is due for any dates of service.

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
09-13-04 & 09-17-04	97110 (5 units X $36.00)	☒ Yes ☐ No	$180.00
09-20-04, 09-24-04 & 09-27-04	97110 (9 units X $36.00)	☒ Yes ☐ No	$324.00
09-13-04 to 03-18-05	97140-59, 97032, 97016, 97110 (with the exceptions above), 99211, A9150-NU, 97035 and 99214-25	☐ Yes ☒ No	$0.00
		TOTAL	$504.00

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 **majority** of 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 10-18-2005, 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.

The Requestor on 10-11-05 submitted an updated table of disputed services and that table is used for this review.

Review of CPT codes 98940, 97140-59, 97032, 97016 and 97110 date of service 10-04-04 and codes 99211, 97032, 97016 and 97110 date of service 01-03-05 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 99080-73 dates of service 11-08-04, 01-12-05 and 03-18-05 denied with denial code "V" (unnecessary treatment with peer review/treatment not recommended by UR). The IRO reviewer determined the office visits on each of the dates of service in dispute to not be medically necessary, therefore, the work status reports are deemed not necessary and no reimbursement is recommended. Per Rule 133.308(p)(5) the IRO decision is deemed a Division decision and order.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308

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 $504.00. 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:

		01-19-06
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

PH. 512/248-9020 **Fax 512/491-5145**

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 17, 2006

Re: IRO Case # M5-06-0078 –01 ___

Texas Department of Insurance, Division of Workers' Compensation:

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 the Division of Workers' Compensation assign cases 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 physician who is Board Certified in Physical Medicine and Rehabilitation, 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 the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, 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. IR 4/29/05
4. Orthopedic consult report 9/10/04, Operative reports 11/11/04, 1/20/05, Dr. Newton
5. Follow up notes 11/15/04, 5/11/04, Dr. Newton
6. Treatment records 1/24/05 – 2/18/05, Dr. Weddle
7. MRI reports right knee 10/15/04, left knee 7/30/04, right elbow 7/20/04

History

The patient is a 64-year-old female who in ___ slipped and fell, landing on her knees and right elbow. The patient injured her left knee more than her right knee. She was initially treated by a D.C. The patient was referred to an orthopedic surgeon for evaluation on 9/10/04. The surgeon recommended four additional weeks of physical therapy. The patient's knee problems persisted, and after MRI evaluation surgery was recommended for both knees. On 11/11/04 the patient underwent left knee arthroscopy with partial medial meniscectomy, abrasion chondroplasty of the patellofemoral joint, synovectomy involving the medial peripatellar area and anterior compartment with complete resection of the plica. Post operative follow up notes on 11/15/04 recommend continued physical therapy, and plan for right knee surgery. On 1/20/05, the patient underwent right knee arthroscopy with partial medial and lateral meniscectomy, abrasion chondroplasty of the patella, and limited synovectomy of the

anterior compartment. Based on the records provided for this review, the patient's last follow up visit with her surgeon was on 5/11/05. The patient's right knee was doing very well. She continued to complain, however, of some anterior knee pain on the left. The surgeon offered the patient a steroid injection to the left knee, which the patient declined.

Requested Service(s)
Office visits, manual therapy technique, electrical stimulation, vasopneumatic devices, therapeutic exercises, nonprescription drug, ultrasound. 9/13/04 – 3/18/05.

Decision
I disagree with the carrier's decision to deny the requested therapeutic exercises 9/13/04 and 9/17/04, and up to three units of therapeutic exercises on each of the dates9/20/04, 9/24/04, and 9/27/04.
I agree with the decision to deny the remainder of the requested services.

Rationale
The patient was evaluated by an orthopedic surgeon on 9/10/04. The surgeon stated that the patient had been improving with physical therapy and he recommended another four weeks of physical therapy in an effort to avoid surgery. Therapy sessions of more than 45 minutes, or three units of services, exceed current guidelines and are not medically necessary. Afterwards, the patient was determined to not be progressing, and she went on to have arthroscopic surgery in both knees. Post surgery, the patient should have continued with a home exercise program. The medical necessity of continued supervised physical therapy is not documented in the records provided for this review.

This medical necessity decision by an Independent Review Organization is deemed to be a Worker's Compensation decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have a right to appeal the decision. The decision of the Independent Review organization is binding during the appeal process.

If you are disputing a decision other than a spinal surgery prospective decision, the appeal must be made directly to the district clerk in Travis County (see Texas Labor Code sec. 413.031). 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. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

_____
Daniel Y. Chin, for GP