



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	
Requestors Name and Address: Neuromuscular Institute of Texas 9502 Computer Drive, Suite 100 San Antonio, Texas 78229	MDR Tracking No.: M5-06-0899-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Hartford Underwriters Insurance Rep Box # 27	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: None submitted

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

No response 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)
01-25-05 to 06-07-05	G0283, 97140-59, 97110 and 95831	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 02-07-06, 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 99245 date of service 01-25-05 denied with denial code "L" (not treating doctor). The provider of service was not the treating doctor of record. No reimbursement recommended.

CPT code 97140-59 date of service 02-23-05 denied with denial code "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). The Requestor did not submit copies of services billed on 02-23-05 per Rule 133.307(e)(2)(A), therefore, the Medical Review Division cannot determine whether code 97140-59 was global to other services billed on the date of service in dispute. No reimbursement recommended.

CPT code 97140-59 date of service 03-09-05 denied with denial code "W1" (Workers Compensation State Fee Schedule Adjustment). The carrier has made no payment. Reimbursement is recommended in the amount of **\$31.78** (amount billed by the Requestor).

CPT code 97110 (3 units) date of service 03-09-05 denied with denial code "W1" (Workers Compensation State Fee Schedule Adjustment). The carrier has made no payment. Reimbursement is recommended in the amount of **\$100.68**.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 133.307(e)(2)(A) and 134.202

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 reimbursement in the amount of \$132.46. 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:

04-20-06

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

Phone 512/248-9020
IRO Certificate #4599

Fax 512/491-5145

NOTICE OF INDEPENDENT REVIEW DECISION

April 3, 2006

Re: IRO Case # M5-06-0899 –01 amended 4/5/04

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, 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 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 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 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. Denial letters
4. Medical records 9/23/04 – 1/12/06, Dr. Burdin
5. Medical records 9/29/04 – 1/17/05, Dr. Kothmann
6. Clinical notes 9/29/04 – 10/5/04, M. Dedmon
7. Medical records 1/25/05 – 5/5/05, Dr. Lampert
8. EMG/NCS report 11/9/05, Dr. Hirsch
9. Clinical interview 11/3/04, Dr. Bobele
10. Occupational therapy treatment notes 2/14/05 – 1/12/06
11. PPE 6/7/05
12. MRI report left shoulder 7/22/04
13. X-ray cervical spine report 9/27/04
14. MRI report lumbar spine 2/22/05
15. MRI cervical spine report 7/13/04

History

The patient was injured in ___ when she fell down a flight of stairs. She reported pain in her neck and left arm as a result of the fall. A 7/13/05 MRI of the cervical spine showed a small to moderate central disk protrusion at C4-5, and spondylosis at C5-6. A 7/22/04 MRI of the left shoulder found degenerative joint disease involving the acromioclavicular joint and calcific tendonitis of the supraspinatus tendon. X-rays of the cervical spine on 9/27/04 showed calcific tendonitis involving the rotator cuff. The

patient was treated with chiropractic modalities as well as pain medications. Electrodiagnostic testing on 11/9/04 was normal. The patient underwent surgery to the left shoulder in December 2004. According to a letter of denial from the carrier, post operative physical therapy began on 2/13/04. The patient continued in physical therapy until 5/11/05.

Requested Service(s)

Electrical stimulation, manual therapy technique, therapeutic exercises, muscle testing
3/23/05 – 6/7/05

Decision

I agree with the carrier's decision to deny the requested physical therapy services and muscle testing. 3/23/05 – 6/7/05

Rationale

The patient began post-operative physical therapy on 12/13/04. She initially was treated with passive modalities and joint manipulation. On 2/14/05 she began active physical therapy exercises. Current guidelines recommend 14 weeks of post operative physical therapy. In this case, 14 weeks concluded on 3/22/05. At that point the patient had had five weeks of active exercises, and was able to continue with a home exercise program on her own. There would be no need for formal, supervised 1:1 physical therapy to continue doing the same exercises.

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

If you are unhappy with all or part of this decision, you have the 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 a district court in Travis County (see Texas Labor Code 413.031). An appeal to the 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 must be received by the Division of Workers' Compensation, chief Clerk of Proceedings, within then (10) days of your receipt of this decision.

Sincerely,

Daniel Y. Chin, for GP