

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-1114.M5**

MDR Tracking Number: M5-04-1852-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-24-04.

The IRO reviewed massage therapy, ultrasound therapy and therapeutic exercises rendered from 11-21-03 through 12-01-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 05-10-04, 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 99080-73 date of service 11-18-03 was denied with denial code U. This service is a TWCC required report. The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$15.00 is recommended per the Medical Fee Guideline effective 08-01-03. Per Rule 133.1(3)(A-D) no proof of billing for code 99080-73 listed on the table of disputed services for dates of service 11-28-03 and 12-01-03 was submitted by the requestor; therefore no reimbursement for code 99080-73 for dates of service 11-28-03 and 12-01-03 is recommended.

## ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for date of service 11-18-03 in this dispute.

This Findings and Decision and Order are hereby issued this 27<sup>th</sup> day of September 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

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### NOTICE OF INDEPENDENT REVIEW DECISION

May 2, 2004

**Re: IRO Case # M5-04-1852-01**

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 by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. 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 3/13/03-11/18/03
2. Explanation of benefits
3. Letter dated 4/5/04
4. Report 11/21/03
5. Reports from treating D.C. 11/18/03, 12/1/03
6. TWCC work status reports
7. Therapy notes
8. D.C. treatment notes
9. Requests for reconsideration 1/27/04, 3/4/04

#### History

The patient injured his left index finger on \_\_\_\_\_. He was treated by an M.D., and then received chiropractic treatment.

#### Requested Service(s)

Massage therapy, ultrasound therapy, therapeutic exercises 11/21/03 –12/1/03

#### Decision

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

#### Rationale

The patient suffered a minor, non-displaced fracture of the distal phalanx of the index finger with subungual hematoma. The nail was removed surgically. Treatment from a chiropractor was not appropriate. According to the records provided, this was a very minor injury. The only follow up treatment that would have been necessary would have been examination by a medical doctor to make sure that the finger was healing and that no

infection was present. The finger would have healed without further conservative treatment with a home-based stretching and strengthening exercise program. The supervised massage, ultrasound and manipulation were neither recommended by the original treating doctor nor necessary. Chiropractic treatment was too intense and inappropriate in this case.

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

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Daniel Y. Chin, for GP