

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 May 6, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening, initial and additional hours; educational supplies; office visits; physical therapy re-evaluation; therapeutic exercises; hot/cold packs therapy; electrical stimulation; and manual therapy techniques were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 June 29, 2004, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 99080-73 for date of service 10/16/03 denied as "V". Per Rule 126.5 the TWCC-73 is a required report. Therefore, per Rule 133.106(f) reimbursement in the amount of \$15.00 is recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to date of service _____ 10/16/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 24th day of January _____ 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division
MF/mf
Enclosure: IRO Decision

Envoy Medical Systems, LP

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IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 31, 2004

Re: IRO Case # M5-04-2898, amended 1/10/05

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 physician who is Board Certified in Orthopedic Surgery, 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 service
2. Explanation of benefits
3. Request for reconsideration
4. Impairment rating
5. D.C. response to peer review 10/16/03
6. Peer reviews 10/15/03, 7/17/03

7. Work hardening progress notes
8. M.D. evaluation 8/6/03
9. Neurological evaluation 6/24/04
10. Orthopedic surgeon office notes 9/02 – 6/03
11. Operative report 2/28/03
12. FCE 6/25/03

History

The patient suffered an over-use injury to her right upper extremity that was reported on _____. She performed repetitive grasping activities. The patient was treated with conservative measures by a company doctor. The patient sought care from the treating D.C. on 4/10/02, and was diagnosed with strain of the right elbow, lateral epicondylitis, and olecranon bursitis on the right. The patient was also seen by an orthopedic surgeon in April 2002 and was diagnosed with overuse syndrome and lateral epicondylitis, and continued chiropractic modalities and a nerve test were recommended. The patient also developed shoulder pain, and this was treated with chiropractic therapy. An MRI of the shoulder obtained in 6/02 showed diffuse thickening of the supraspinatus tendon, a small tear in the supraspinatus, early signs of ulnar neuropathy, and right-sided carpal tunnel syndrome. Injections into the shoulder and elbow were performed. The patient ultimately underwent a lateral epicondylar fasciotomy with partial epicondylectomy on 9/20/02. She was seen for post-surgical rehabilitation in 10/02 and 11/02. The patient continued to complain of pain in her right shoulder and elbow, and she underwent right shoulder arthroscopy and subacromial decompression on 2/28/03. A 6/25/03 FCE report suggested that the patient was a candidate for a work hardening program. A 7/17/03 peer review suggested that continued chiropractic care was not medically necessary.

Requested Service(s)

Work hardening initial and additional hours, educational supplies, office visits, physical therapy re-evaluation, therapeutic exercises, hot/cold packs therapy, electrical stimulation, manual therapy techniques, 6/30/03 – 10/16/03

Decision

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

Rationale

The 6/25/03 FCE results indicate that the patient was able to return to a light capacity work load with lifting restrictions. Based on the records provided for this review, work hardening program that was started did not include an adequate psychological assessment. The objective findings and the lack of objective improvement argue against the recommendation of a work hardening program and the other requested services. Furthermore, on 6/2/03 the orthopedic surgeon evaluating the patient noted that she had 160 degrees of abduction and 90 degrees of external rotation. The orthopedic surgeon also noted that the patient had recovered from her lateral epicondylar release and that her elbow was doing considerably better. At that point, the patient's pain was rated at 4/10. These objective findings do not support the need for the requested services.

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

Daniel Y. Chin, for GP