

**MDR Tracking Number: M5-04-3182-01**

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 05-24-04.

The IRO reviewed office visits, chiropractic manipulative treatments spinal 1-2 regions, therapeutic exercises, unlisted therapeutic procedures, manual therapy, functional capacity evaluation rendered from 08-08-03 through 10-03-03 that were denied based "V".

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 07-12-04, 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 billed on dates of service 08-26-03, 09-26-03 and 12-16-03 along with CPT code 99455-VR billed on date of service 12-16-03 denied with denial code "V". These services are required TWCC reports and are reviewed as fee issues. The requestor submitted relevant information to support delivery of service for both CPT code 99080-73 for dates of service 08-26-03, 09-26-03 and 12-16-03 as well as CPT code 99455-VR for date of service 12-16-03. The services were denied by the carrier for unnecessary treatment per peer review. Reimbursement is recommended in the amount of \$45.00 (\$15.00 per date of service) for CPT code 99080-73 and reimbursement in the amount of \$46.67 is recommended for CPT code 99455-VR per the Medical Fee Schedule effective 08-01-03. Total reimbursement is recommended in the amount of \$91.67.

**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 dates of service 8-26-03 through 12-16-03 in this dispute.

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

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

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**NOTICE OF INDEPENDENT REVIEW DECISION**

August 17, 2004

**Re: IRO Case # M5-04-3182**

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, 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 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 service
2. Explanation of benefits
3. Request for reconsideration 4/15/04
4. Review 8/7/03
5. TWCC-69 report of medical evaluation 9/29/03
6. MRI report lumbar spine 1/20/03
7. M.D. report 1/22/03
8. Orthopedist reports 2/28/02, 2/19/02, 3/25/03, 6/5/03
9. M.D. Report 3/1/03
10. M.D. report 7/15/03
11. Electrodiagnostic report 2/28/03
12. Operative reports 4/3/03, 4/16/03, 5/14/03, 5/22/03
13. Prescription for continued physical therapy 5/22/03
14. D.C. reports 8/26/03, 9/26/03, 12/16/03
15. Report 8/8/03
16. TWCC work status reports
17. D.C. treatment notes and exercise sheets

#### History

The patient injured her back when she lifted a sofa in \_\_\_\_\_. X-rays of the lumbar spine, an MRI of the lumbar spine, and electrodiagnostic studies were performed. The patient was treated with epidural steroid injections and chiropractic treatment.

#### Requested Service(s)

Office visits, chiropractic manipulative treatments spinal 1- 2 regions, therapeutic exercises, unlisted therapeutic procedures, manual therapy, functional capacity evaluation 8/8/03-10/3/03

#### Decision

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

#### Rationale

The patient had an extensive course of physical therapy and chiropractic treatment prior to the dates in dispute without relief of symptoms or improved function. A 9/18/03 FCE report states that the patient's VAS was still a 7/10, which is the same as it was at the time of injury. The FCE also shows that tests had to be discontinued because of increased pain

and antalgia.

A 1/20/03 MRI showed a broad-based posterior annular bulge at L4-L5 and a grade 1 anterolisthesis bilaterally at L5. A 2/28/03 EMG revealed a moderate to severe right-sided L5-S1 radiculopathy. The prognosis for chiropractic treatment with these objective findings would be poor at best. Even lumbar ESIs failed to be beneficial. He patient's ongoing and chronic care did not produce measurable or objective improvement, did not appear directed at progression for return to work, and was not provided in the least intensive setting. Treatment for the dates in dispute was inappropriate and over utilized. The treatment notes lacked objective, quantifiable findings to support most of the treatment given to the patient. Based on the records provided, it appears that the patient's condition plateaued in a diminished state prior to the dates in dispute, and further treatment was unreasonable and unnecessary.

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