

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 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 14, 2004.

The IRO reviewed CPT Codes 99213, 97110, 97112, 99199, 99213-MP, 97010, 97014, 97039, 97250, 99358, 99090, 99204, 97035, 97032, G0283, 97150, and 97140 from 06/11/03 through 12/05/03 that were denied based upon PEC "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. 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.

- CPT Code 99080-73 for date of service 07/17/03 and 07/30/03. The carrier denied CPT Code 99080-73 with a "V" for unnecessary medical treatment based on a peer review; however, per Rule 129.5 the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter; therefore, reimbursement in the amount of \$30.00 (\$15.00 x 2) 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 dates of service 07/17/03 and 07/30/03 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 Order is hereby issued this 17<sup>th</sup> day of December, 2004

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division

MF/mf  
Enclosure: IRO decision

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**

Ph. 512/248-9020  
IRO Certificate #4599

Fax 512/491-5145

**NOTICE OF INDEPENDENT REVIEW DECISION**

October 25, 2004

**Re: IRO Case # M5-04-3502** amended 12/6/04

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 physician who is Board Certified in Physical Medicine and Rehabilitation, 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. Operative report
4. Peer review 1/23/04

5. Independent medical examination 5/13/03
6. Record review 6/5/03
7. D.C. office notes
8. M.D. office notes
9. Electrodiagnostic test report 5/27/03
10. Office note 6/11/03
11. MRI cervical spine report 7/9/03
12. Impairment rating 4/20/04
13. FCE reports
14. D.C. daily progress notes

#### History

In \_\_\_ the patient reported pain in her neck and upper extremities that had bothered her for the previous year. She had been treating her symptoms with over-the-counter medication, a wrist splint and changes in her work station. The patient continued to suffer symptoms, aggravated by working 8-10 hours a day on a keyboard. The patient presented to the treating D.C. on 10/31/03, and was diagnosed with cervical radiculitis, carpal tunnel syndrome, cubital tunnel syndrome, cervical strain muscle spasm. Beginning 4/4/03, the patient was also treated by an M.D. and was given anti-inflammatory medication and trigger point injections. The patient underwent electrodiagnostic testing on 5/27/03. NCS and somatosensory evoke potentials were normal, and the EMG was abnormal. The patient was referred to an M.D. on 6/11/03 who recommended physical therapy and an MRI of the cervical spine. The MRI was reported as normal. On 8/5/03 the patient underwent a left carpal tunnel release. She began post-operative physical therapy and progressive rehabilitation on 9/8/03. She then underwent a right carpal tunnel release on 10/13/03. on 4/20/04 the patient was determined to be at MMI, and was assigned a 12% whole person impairment rating.

#### Requested Service(s)

Office visits, therapeutic procedure, neuromuscular reeducation, unlisted special service, office visits with manipulations, hot or cold packs, electrical stimulation, unlisted modality, myofascial release, office visit, analysis information, ultrasound, group therapeutic procedures 6/11/03 – 12/5/03

#### Decision

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

#### Rationale

In March 2003 the patient reported a one-year history of neck and upper extremity pain of insidious onset, and no specific injury. She was treated extensively with chiropractic modalities and physical therapy. She also underwent weight training. In addition, the patient was treated by an M.D. with medications and trigger point injections. In all, the patient underwent over nine months of treatment from her treating D.C. There was no documentation of improvement. Chiropractic and physical medicine treatments would not be indicated beyond 12 weeks without some documentation of medical necessity. The patient underwent electrodiagnostic testing by another D.C. and was diagnosed with carpal

tunnel syndrome in spite of normal nerve conduction studies. She underwent a left carpal tunnel release, followed by a right carpal tunnel release two months later. Following surgery, the patient continued with treatment with her D.C. Chiropractic treatment would not be medically necessary following carpal tunnel release surgery. Physical therapy is not routinely ordered after this type of surgery. There is no documented indication in the notes of a need for the patient to undergo treatment with modalities or a therapist.

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

---

Daniel Y. Chin, for GP