

**TEXAS WORKERS' COMPENSATION COMMISSION  
MEDICAL REVIEW DIVISION, MS-48  
MEDICAL DISPUTE RESOLUTION**

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 9-22-04.

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 physical performance tests rendered on 3/2/04 and 5/7/04 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.

**CPT code 97799-CP:** In accordance with §134.600 (h) (4), the requestor provided copies of the preauthorization letters dated 2/20/04, 3/12/04, and 4/2/04 for a total of 30 sessions in the Chronic Pain Program. Thirty-one (31) of these preauthorized services were rendered from 3/3/04 through 5/6/04. The carrier denied seventeen (17) sessions from 3/3/04 through 4/06/04 for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments and/or service for which the health care provider has obtained preauthorization under Chapter 134 of this title." The remaining fourteen (14) sessions were denied with "D", duplicate bill but no payment was rendered. Therefore, **reimbursement is recommended** for 30 preauthorized sessions in the Chronic Pain Program in the amount of \$29,125 in accordance with §134.600 (b)(1)(B).

**CPT code 99071** was denied by the carrier with the statement: "this is a non-covered or bundled procedure according to Medicare." The descriptor for this code according to Encoder Pro is: "*Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician.*" Since these items are to be provided and paid for by the physician, **reimbursement is not recommended.**

This Findings and Decision is hereby issued this \_\_\_18\_\_\_ day of January 2005.

Medical Dispute Resolution Officer  
Medical Review Division

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 TWCC reimbursement methodologies for Return to Work Rehabilitation Programs for dates of service after August 1, 2003 per Commission Rule 134.202(e)(5)(E) 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 3/3/04 through 5/6/04 as outlined above 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 \_\_18\_\_ day of January 2005.

\_\_\_\_ Manager  
Medical Dispute Resolution  
Medical Review Division

HHB/rlc

Enclosure: IRO Decision

**Envoy Medical Systems, LP**  
**1726 Cricket Hollow**  
**Austin, Texas 78758**  
Fax 512/491-5145

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

November 22, 2004

**Re: IRO Case # M5-05-0321 \_\_\_\_\_**

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 Anesthesiology and Pain Management, 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. Physical performance evaluation 3/2/04
4. Behavioral notes, billing sheets and pain management program records
5. Treatment summary and extension request 3/8/04
6. Initial pain evaluation 3/29/04
7. Letter of medical necessity 4/14/04
8. Discharge summary 5/6/04
9. Examination reports 5/7/04

### **History**

The patient has had left shoulder, arm and hand pain since a March 2000 injury. There is significant depression associated with her pain.

### Requested Service(s)

Performance testing, unlisted physical medicine procedures, books/educ supplies 3/2/04 – 5/7/04

### Decision

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

### Rationale

The physician's notes of 3/29/04 indicate that the patient is taking Bextra only. No antidepressants or neuropathic medications were prescribed. The first line of treatment for depression and this type of pain is medications. It is not reasonable or necessary to perform a 30-day behavioral program without first instituting an aggressive antidepressant and co-analgesic regimen

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