

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 August 30, 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 CPT Codes 99214, G0283, 98940, 97140, E0230, and 97110 for dates of service 09/22/03 through 11/10/03 that were denied based upon "V" 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 September 27, 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.

On October 21, 2004 the requestor's representative was contacted to check on the status of the fee issues in the dispute. The requestor's representative informed MDR that the insurance carrier had made payment for CPT Codes 97140, 98940, and G0283 for date of service 10/8/03 and were no longer in dispute. The remaining CPT code is 99080-73, listed on three separate dates of service, is the only item in dispute.

- The carrier denied CPT Code 99080-73 for dates of service 10/07/03, 10/20/03, and 11/10/03 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Per Rule 129.5 reimbursement in the amount of \$45.00 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 129.5 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 10/07/03, 10/20/03, and 11/10/03 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 22<sup>nd</sup> day of October 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 13, 2004

**Re: IRO Case # M5-05-0040-01**

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 in 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. D.C. treatment notes
4. D.C. daily treatment logs
5. TWCC work status reports
6. Report 12/8/03
7. Electrodiagnostic study report 10/28/03
8. Reviews 8/13/04, 4/2/03
9. Review 6/3/03
10. D.C. reports

#### History

The patient injured her arms and neck in \_\_\_\_\_. She sought chiropractic treatment and had some 21 treatments as of 6/3/02. She continued treatment through February 2003. Based on the records provided for this review, the patient did not have between February 2003 and 9/22/03, when she sought treatment with her chiropractor. She has been treated with chiropractic manipulation and therapeutic exercises

#### Requested Service(s)

Office visits, electrical stimulation, chiropractic manipulative treatment, manual therapy, ice cap or collar, therapeutic exercises 9/22/03 – 11/10/03

#### Decision

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

#### Rationale

The patient had more than an adequate trial of chiropractic treatment with little, if any, relief of symptoms or improved function. Treatment was inconsistent for over two years post injury. Based on the findings of the cervical MRI, the prognosis for any permanent relief of symptoms or improved function with chiropractic treatment would be poor. Multiple levels of degenerative disk disease and canal stenosis and disk bulging will cause recurring flare-ups necessitating pain medications and/or injections, which the patient apparently refused. Treatment beyond February 2003 was not documented as medically

necessary; the documentation lacked subjective pain levels, objective findings such as DTRs, ROMs and strength measurements. The chronic and ongoing treatment is not reasonable and necessary in the absence of functional objective improvements. Treatment based on minimal subjective complaints fails to be reasonable and necessary. The failure of conservative treatment does not establish a medical rationale for additional non-effective treatment.

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

---

Daniel Y. Chin, for GP