

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-4187.M5**

MDR Tracking Number: M5-05-0070-01

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 August 31, 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 97139-EU, 97110, 98940, 97150, 97124, 95851, 98943, and 99080 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 November 17, 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 99070, Refreezable Cryo Packs, for date of service 09/09/03 denied as "NC – A service has been billed for which a payment is not allowed under the Fee Schedule. The service is either not covered or the service is not recognized as a valid service". Per Rule 134.202(c)(6) reimbursement is recommended. Per the rule referenced, the carrier shall assign a relative value.
- CPT Code 99070, Biofreeze, for date of service 09/09/03 denied as "NC – A service has been billed for which a payment is not allowed under the Fee Schedule. The service is either not covered or the service is not recognized as a valid service". Per Rule 134.202(c)(6) reimbursement is recommended. Per the rule referenced, the carrier shall assign a relative value.
- CPT Code 99070, Consumable TENS Supplies, for dates of service 09/12/03 and 10/22/03 denied as "F, AA – The charge exceeds an amount that would appear

- reasonable. (Medicare)” Per Rule 134.202(b) and (c)(6) additional reimbursement is not recommended.
- CPT Code 97150 for date of service 09/19/03 denied as “Y, NH – Coverage of a group procedure is determined on an individual case basis. Documentation of the specific services rendered and the number of persons in the group must be submitted.” Per Rule
- 134.202(b) Medicare requirements under the Local Coverage Determination (LCD) requires the documentation of the specific treatment and number of person in the group. Submitted documentation does not document the specific services rendered or the number of person in the group; therefore, reimbursement is not recommended.
- CPT Code 99211-25 for date of service 09/26/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per 134.202(b) requestor submitted convincing evidence to support service were rendered as billed. Reimbursement in the amount of \$23.35 ( $\$18.69 \times 125\%$ ) is recommended.
- CPT Code 97110 for dates of service 10/08/03, 10/10/03, 10/13/03, 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement is not recommended.
- CPT Code 98940 for dates of service 10/08/03, 10/10/03, 10/13/03, and 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement in the amount of \$120.52 ( $\$30.13 \times 4$ ) is recommended.
- CPT Code 97124 for dates of service 10/08/03, 10/10/03, 10/13/03, and 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement in the amount of \$102.76 ( $\$29.69 \times 4$ ) is recommended.
- CPT Code 97150 for dates of service 10/08/03, 10/10/03, 10/13/03, and 10/15/03.

Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) Medicare requirements under Local Coverage Determination (LCD) requires the documentation of the specific treatment and number of person in the group. Submitted documentation does not document the specific services rendered or the number of person in the group; therefore, reimbursement is not recommended.

- CPT Code 97139-EU for dates of service 10/08/03, 10/10/03, 10/13/03, and 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement in the amount of \$73.00 (\$18.25 x 4) is recommended.
- CPT Code 98943 for dates of service 10/08/03, 10/10/03, 10/13/03, and 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) and (c)(6) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement is recommended and the carrier shall assign a relative value.
- CPT Code 97012 for dates of service 10/10/03, 10/13/03, and 10/15/03. Neither party submitted EOBs; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement in the amount of \$51.60 (\$17.20 x 3) is recommended.
- CPT Code 99212-25 for date of service 10/15/03. Neither party submitted an EOB; therefore, this code will be reviewed in accordance with TWCC Rules. Per Rule 134.202(b) the requestor has provided convincing evidence to support services were rendered as billed. Reimbursement in the amount of \$41.91 is recommended.
- CPT Code 97750-MT for date of service 10/16/03 denied as “F”. The requestor billed \$233.80; the respondent reimbursed the requestor \$187.11 leaving a balance due of \$46.69. Per Rule 134.202(b) the requestor has provided convincing evidence to support the services were rendered as billed. Additional reimbursement in the amount of \$46.69 ( $\$33.40 \times 7 = \$233.80 - \$187.11$ ) is recommended.
- CPT Code 99213 for date of service 11/14/03 denied as “Y, JM – Accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid. Please refer to the applicable Medical Fee Guideline and/or Medicare Guideline for the correct code or modifier for the service rendered.” The code used is a

valid code according to the Medicare Fee Schedule. Per Rule 134.202(b) the requestor submitted SOAP notes to support the services were rendered as billed. Reimbursement in the

amount of \$58.99 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 as follows:

- in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c)(6)
- 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 09/09/03 through 11/14/03 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 7<sup>th</sup> day of January 2005.

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**

November 9, 2004

**Re: IRO Case # M5-05-0070-01**

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, 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 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. Summary of provider's position 10/7/04
4. Report 12/19/03
  
5. D.C. treatment notes
6. D.C. therapeutic procedures charts
7. D.C> testing reports

8. D.C. medical narrative reports
9. TWCC work status reports
10. D.C. range of motion reports
11. MRI reports right wrist and lumbar spine 10/17/03
12. Initial FCE 11/24/04

#### History

The patient injured his right wrist and low back in \_\_\_\_ when he attempted to lift an object and put it on a shelf. He initially went to an ER, and then to a medical center where he received one physical therapy treatment. He presented to his treating D.C. on 9/9/03. The patient has undergone numerous medical evaluations and has been treated with medication, therapeutic exercises and chiropractic treatment.

#### Requested Service(s)

Electric stimulation, therapeutic exercises, chiro manipulation, massage, kinetics, range of motion, mechanical traction, muscle testing, special reports 9/9/03 11/18/03

#### Decision

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

#### Rationale

The patient received an adequate trial of conservative treatment with minimal relief of symptoms and improved function. Treatment was necessary to try and alleviate the patient's symptoms, and based on the records provided for this review the benefit company's approval of much of the D.C.'s treatment was appropriate.

The D.C.'s documentation was very thorough. At times the patient's VAS showed improvement, but soon increased without reason. No evidence was provided showing that the provided treatment actually cured or relieved the effects of the patient's injury, promoted the patient's recovery, or helped the patient return to employment. Temporary relief of pain is not equivalent to relieving the effects of the patient's injury. A report on 12/9/03 indicated that the patient was "unresponsive so far to three months of conservative intervention." The patient was diagnosed with sprain/strain of the right wrist and lumbar spine, and he should have responded with appropriate treatment in six to eight weeks, but he failed to do so. Multiple referrals to medical specialists in December 2003 indicate that the D.C.'s treatment failed to be beneficial to the patient. An 11/24/03 FCE report indicates that the patient showed multiple limitations regarding lifting, coordination, pushing, pulling, range of motion, as well as severe psychological barriers and increased pain with testing. These results also indicate that the D.C.'s treatment failed to be beneficial to the patient. Based on the records provided for review, the treatment in dispute was over utilized and inappropriate.

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

---

Daniel Y. Chin, for GP