

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 October 25, 2004.

The IRO reviewed office visits; mechanical traction; electrical stimulation, unattended; chiropractic manipulations; massage therapy; therapeutic exercises; and manual therapy technique that was denied based upon "U".

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.

The IRO reviewer found that office visits; mechanical traction; electrical stimulation, unattended; chiropractic manipulations; massage therapy; therapeutic exercises; and manual therapy technique for dates of service 01/19/04 through 02/19/04 **were** found to be medically necessary. The office visits; mechanical traction; electrical stimulation, unattended; chiropractic manipulations; massage therapy; therapeutic exercises; and manual therapy technique for dates of service 02/20/04 through 04/26/04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for office visits; mechanical traction; electrical stimulation, unattended; chiropractic manipulations; massage therapy; therapeutic exercises; and manual therapy technique.

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.

On November 19, 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 14-days of the requestor's receipt of the Notice.

- CPT Code 72070-WP for date of service 01/09/04 denied as "YO - Reimbursement was reduced or denied after reconsideration of treatment/service billed". Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of \$42.29 ( $\$10.91 \times 125\% = \$13.64 + \$22.92 \times 125\% = \$28.65$ ) is recommended.
- CPT Code 72100-WP for date of service 01/09/04 denied as "YO - Reimbursement was reduced or denied after reconsideration of treatment/service billed". Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of \$43.61 ( $\$11.30 \times 125\% = \$14.13 + \$23.58 \times 125\% = \$29.48$ ) is recommended.

- CPT Code 72020-WP for date of service 01/09/04 denied as “YO - Reimbursement was reduced or denied after reconsideration of treatment/service billed”. Per Rule 134.202(b) and the Medicare Fee Schedule reimbursement in the amount of \$27.35 ( $\$7.63 \times 125\% = \$9.54 + \$14.25 \times 125\% = \$17.81$ ) is recommended.
- HCPCS Code E0230 for date of service 01/09/04 denied as “YO - Reimbursement was reduced or denied after reconsideration of treatment/service billed”. Per Rule 133.307(g)(3)(B) the clinical notes do not indicate DME products were distributed to the claimant. Therefore, reimbursement is not recommended.
- CPT Code 98940 for dates of service 01/20/04, 01/26/04, 03/26/04, 03/29/04, 04/02/04, 04/05/04, and 04/12/04. Neither party submitted EOBs. Per Rule 134.202(b) and the Medicare Fee Schedule, clinical notes support services were rendered as billed. Reimbursement in the amount of \$219.45 ( $\$25.08 \times 125\% = \$31.35 \times 7$ ) is recommended.
- CPT Code 99215 for date of service 01/27/04. Neither party submitted EOBs. Per Rule 134.202(b) and the Medicare Fee Schedule, the re-assessment notes support services were rendered as billed. Reimbursement in the amount of \$75.00 is recommended.
- CPT Code 97012 (10 units total) for dates of service 01/27/04 through 02/11/04. Neither party submitted EOBs. Per Rule 134.202(b) and the Medicare Fee Schedule, the treatment notes support services were rendered as billed. Reimbursement in the amount of \$179.10 ( $\$14.33 \times 125\% = \$17.91 \times 10$ ) is recommended.
- CPT Code 97124-59 (10 units total) for dates of service 01/27/04 through 02/11/04. Neither party submitted EOBs. Per Rule 134.202(b) and the Medicare Fee Schedule, the treatment notes support services were rendered as billed. Reimbursement in the amount of \$262.80 ( $\$21.02 \times 125\% = \$26.28 \times 10$ ) is recommended.
- CPT Code 99080-73 for dates of service 03/03/04 and 03/24/04. An EOB was not submitted by either party for date of service 03/03/04 and the submitted EOB for date of service 03/24/03 shows payment was recommended. The respondent did not submit convincing evidence to support the recommended payment for DOS 03/24/04 was made to the requestor. Per Rule 129.5 the TWCC-73 is a required report. Per Rule 133.106(f) reimbursement in the amount of \$30.00 ( $\$15.00 \times 2$ ) is recommended.

This Decision is applicable for dates of service 01/09/04 through 04/12/04 in this dispute.

This Decision is hereby issued this 24<sup>th</sup> day of January 2005.

Marguerite Foster  
Medical Dispute Resolution Officer  
Medical Review Division  
MF/mf

### **ORDER**

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 TWCC reimbursement methodologies regarding Work Status Reports for dates of service after August 1, 2003 per Commission Rule 134.202 (e)(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 01/09/04 through 04/12/04 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 24<sup>th</sup> day of January 2005.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/mf

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**

December 29, 2004

**Re: IRO Case # M5-05-0625-01 amended 1/20/05**

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, 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. Reports 5/13/04, 4/29/04
4. Initial D.C. reports 1/9/04, 2/17/04

5. MRI report lumbar spine 5/7/04
6. SOAP notes
7. D.C. examination forms
8. TWCC work status reports
9. RTW form from D.C.

### History

The patient injured his lower back in \_\_\_ when he pulled or dragged a heavy hose and felt a sudden onset of lower back pain. The pain persisted, and he saw the treating D.C. on 1/9/04 for chiropractic treatment. The patient was also evaluated by an M.D. and was prescribed medication.

### Requested Service(s)

Office visit, mechanical traction, electrical stimulation unattended, chiropractic manipulative treatment spinal, massage therapy, office visit level V, therapeutic exercises, manual therapy technique, CPT code 99214. 1/9/04 – 4/26/04

### Decision

I disagree with the carrier's decision to deny the requested services 1/19/04 through 2/19/04.

I agree with the decision to deny the requested services after 2/19/04.

### Rationale

The patient had an adequate trial of conservative treatment that failed to relieve his symptoms or improve function. Six weeks of conservative treatment was medically appropriate. However, after six weeks, the patient failed to show any subjective or objective improvement in his condition. On 2/18/04 the D.C. noted that the patient's ROM's were still diminished, flexion antalgia continued, and spasm and tenderness persisted. The patient's subjective complaints and objective findings did not really change throughout his treatment. On 2/19/04 the D.C. noted that, "there is no change in the patient's original assessment."

The failure of conservative therapy does not establish a medical rationale for continuing non-effective treatment. Treatment in this case failed to be beneficial after 2/19/04. treatment after 2/19/04 was not reasonable or necessary.

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