

MDR Tracking Number: M5-05-2240

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 04-13-05.

The IRO reviewed office visits, neuromuscular re-education, manual therapy technique, ultrasound, therapeutic exercises, occupational therapy re-evaluation, telephone call by physician to patient and electrical stimulation rendered from 04-14-04 through 06-11-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order. The amount due in reimbursement from the carrier for the medical necessity issues equals **\$1,372.80 (reimbursement does not include CPT code 99371 as this is a bundled procedure and not a separate fee).**

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 05-05-05, 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 99080-73 dates of service 04-22-04 and 05-21-04 denied with denial code "V" (unnecessary medical treatment with peer review). The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$30.00 (\$15.00 X 2 DOS)**. A Compliance and Practices referral will be made as the carrier is in violation of Rule 129.5.

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees for dates of service 04-14-04 through 06-11-04 totaling \$1,402.80 in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Findings and Decision and Order are hereby issued this 6th day of June 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

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

Phone 512/248-9020

Fax 512/491-5145

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

June 1, 2005

**Re: IRO Case # M5-05-2240 -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 physician who is board certified in Orthopedic Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. 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 services
2. Explanation of benefits
3. Medical records review, Dr. Whitehead
4. IME, Dr. Xellar, 5/29/03
5. MRI reports right shoulder and cervical spine
6. Medical records, Alamo Orthopedics Associates
7. Medical records, Neuromuscular institute of Texas
8. Operative reports 2/19/03, 6/23/04, 11/16/04
9. Medical records, Dr. Hirsch, including ESI and EMG reports
10. IR report, Dr. Burdin

#### History

The patient has a complex history of bilateral upper extremity and neck complaints originating from an injury first claimed in \_\_\_\_\_. Work up revealed poly focal nerve compression including bilateral carpal tunnel syndrome, cubital tunnel syndrome, pronator syndrome with mild fascial syndrome, along with shoulder pain. The patient was treated extensively by multiple physicians in orthopedic, chiropractic and pain management specialties. She received extensive physical therapy. The patient underwent multiple surgeries, including carpal tunnel releases, revision carpal tunnel releases and ulnar nerve transpositions. She also underwent cervical epidural steroid injections.

#### Requested Service(s)

Neuromuscular re-education, manual therapy technique, ultrasound, therapeutic exercises, OV, occupational therapy re-evaluation, telephone call by phys to pt, elec stimulation 4/14/04 – 6/11/04

#### Decision

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

#### Rationale

The D.C.'s and operating surgeon's notes indicate that the patient continued to have significant symptoms of pain, weakness and neuropathy despite multiple carpal tunnel releases. EMG evaluation was negative for ulnar neuropathy. However, the patient continued to have symptoms, as well as scar

problems. The disputed services represent a reasonable attempt at non-operative management prior to recommending ulnar transposition and scar revision. The therapy notes indicate benefit, including improved function with therapy.

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

Sincerely,  
Daniel Y. Chin, for GP