THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NO.:

SOAH DOCKET NO. 453-04-5420.M5

MDR Tracking Number: M5-03-2467-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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 06-05-03.

The IRO reviewed joint mobilization, physical therapy, diagnostic procedure rendered from 12-18-02 through 03-05-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO 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 08-18-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
12-18-02	97750-MT	$43.00 (1 unit)	$0.00	G	$43.00	96 MFG MED GR (I)(E)(3)	G – Not global to any other service billed on this date. The requestor submitted relevant information to support delivery of service. Recommend reimbursement in the amount of $43.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
12-19-02 through 2-5-03 (12 DOS)	97110	$1,680.00 (4 units per day @ $35.00 per unit X 12 DOS	$420.00 ($35.00 paid on each DOS X 12 DOS)	No EOB	$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
12-31-02	99080-73	$15.00 (1 unit)	$0.00	No EOB	DOP	Rule 133.307 (g)(3)(A-F)	The requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
1-6-03 through 1-31-03 (9 DOS)	97265	$387.00 (1 unit per day @ $43.00 X 9 DOS)	$0.00	No EOB	$43.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Recommend reimbursement in the amount of $43.00 X 9 DOS = $387.00
1-8-03	95851	$36.00 (1 unit)	$0.00	No EOB	$36.00	Rule 133.307 (g)(3)(A-F)	The requestor submitted relevant information to support delivery of service. Recommend reimbursement in the amount of $36.00
TOTAL		$2,161.00	$0.00		$2,161.00		The requestor is entitled to reimbursement in the amount of $466.00

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

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 in accordance with the fair

and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-18-02 through 03-05-03 in this dispute.

This Order is hereby issued this 31st day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Envoy Medical Systems, LLC

1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 12, 2003

Re: IRO Case # M5-03-2467 amended 3/29/04

Texas Worker's Compensation Commission:

Envoy Medical Systems, LLC (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 by the State of Texas. 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:

History
The patient injured the fifth digit of his left hand on ___ when he caught his finger in a pulley that was lowing a scaffold. He received stitches in the ER. He received therapy from a company doctor, and then presented to the treating chiropractor for treatment.

Requested Service(s)
Joint mobilization, physical therapy, diagnostic procedure 12/18/02 – 3/5/03

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

Rationale
The patient received extensive therapy, joint mobilization, traction, therapeutic exercises and imaging studies for what appears from the records provided for review to be a very minor injury. A report by a hand surgeon of 2/10/03 repeatedly notes that there was no palpable tenderness to any soft tissues involving the injured hand and finger. Range of motion was full and not painful. There was some pain at the ulnar collateral ligament of the little finger, and strength testing was normal. The hand surgeon diagnosed the patient with a contusion of the digital nerve of the little finger and tendonitis, and noted that it was "unlikely we are going to make it much better since it is probably just a bruise of the nerve." The hand surgeon added, "Simply time will help" and, "I probably wouldn't do anything else for it." Nevertheless, the chiropractor continued treatment after the evaluation by the hand specialist.
The documentation presented indicates that the disputed treatment failed to improve the patient's symptoms or to improve function. Treatment was excessive. In my opinion, it would have been more appropriate and effective to treat the patient with a home—based exercise program and OTC medication. Chiropractic treatment for this type of injury is not reasonable or effective in relieving symptoms or improving function.

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

Sincerely,