

MDR Tracking Number: M5-04-1316-01

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 01-13-04.

The requestor submitted an updated table of disputed services on 10-19-04 and this table is used in the Medical Review Division's review.

The IRO reviewed unlisted modality, office visits, medical conference by physician, application of modality hot/cold pack therapy, electrical stimulation unattended, neuromuscular re-education and therapeutic procedures rendered from 01-15-03 through 11-14-03 that were denied based upon "V".

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 paid 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 05-19-04, 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.

Review of CPT code 99212-MP date of service 01-15-03 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$32.00.

Review of HCPCS code A4550 dates of service 01-15-03, 03-07-03, 05-02-03 and 07-28-03 revealed that neither the requestor nor the respondent submitted copies of EOBs.

The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$180.00 (\$45.00 X 4 DOS).

CPT code 99212-MP date of service 01-24-03 denied with denial code "F" (an evaluation and management code is only reimbursable if documentation indicates the starred procedure was not the major service). No payment has been made by the carrier. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$32.00.

CPT code 99358 dates of service 01-29-03, 03-03-03, 09-08-03 and CPT code 99358-52 date of service 09-14-03 (4 DOS) denied with denial code "N" (under the CPT-4 coding system, only "care beyond the usual service" qualifies for separate reimbursement). The requestor submitted information to support delivery of service. Reimbursement is recommended in the amount of \$168.00 (\$84.00 X 2) for dates of service 01-29-03 and 03-03-03 per the 96 Medical Fee Guideline. Code 99358 is a Medicare bundled code for dates of service 09-08-03 and 09-14-03. No relative value unit has been established. Reimbursement is recommended.

Review of CPT code 99371-11 date of service 03-07-03 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$11.00.

Review of CPT code 99213-MP dates of service 03-07-03, 05-02-03 and 07-28-03 and CPT code 99213 date of service 10-20-03 (4 DOS) revealed that neither the requestor nor the respondent submitted copies of EOBs. The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$144.00 (\$48.00 X 3 for dates of service 03-07-03, 05-02-03 and 07-28-03) and \$66.19 (52.95 X 125%) for date of service 10-20-03.

CPT code 99361 date of service 04-11-03 denied with denial code "N" (submitted documentation does not indicate the specific nature of the care that was coordinated and what was decided). The requestor submitted documentation, however, documentation submitted does not meet criteria. No reimbursement recommended.

CPT code J3490 date of service 04-11-03 denied with denial code "M" (reduced to fair and reasonable). The requestor did not provide information (redacted EOBs) to show their charge billed was a fair and reasonable amount. No additional reimbursement recommended.

CPT code 20550-51 (5 units) date of service 04-11-03 denied with denial code “F” (multiple surgical procedures billed on the same day will be reimbursed at 100% for the major procedure and 50% for each subsequent procedure per surgery ground Rule D, page 64 04-01-96 Texas Medical Fee Guideline). The requestor submitted relevant information to support delivery of service. The requestor billed \$200.00. Per the 96 Medical Fee Guideline Surgery GR I(D)(b) additional reimbursement of \$40.00 is recommended.

CPT code 99361 dates of service 04-11-03, 04-18-03 and 05-23-03 (4 units) denied with denial code “F” (only the treating doctor may bill for case management services). The requestor submitted information that services were billed by the treating doctor. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$212.00 (\$53.00 X 4 units).

Review of CPT code 20550 dates of service 05-02-03 and 07-29-03 revealed that neither the requestor nor the respondent submitted copies of EOBs. The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$80.00 (\$40.00 X 2 DOS).

Review of CPT code 20550-51 date of service 05-02-03 (5 units) and 07-28-03 (7 units) revealed that neither the requestor nor the respondent submitted copies of EOBs. The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$240.00 (\$480.00 billed minus carrier payment of \$240.00).

Review of CPT code J3490 dates of service 05-02-03 and 07-28-03 revealed that neither the requestor nor the respondent submitted copies of EOBs. The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$40.00 (\$20.00 X 2 DOS).

CPT code 99213-MP dates of service 05-14-03 and 06-30-03 denied as duplicates (reimbursement for procedure withheld due to previous submission). The carrier does not indicate what submission CPT code 99213-MP is a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$96.00 (\$48.00 X 2 DOS).

CPT code 20550 date of service 05-14-03 denied as a duplicate (reimbursement for procedure withheld due to previous submission). The carrier does not indicate what submission CPT code 20550 is a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$40.00

CPT code 20550-51 (7 units) date of service 05-14-03 denied as a duplicate (reimbursement for procedure withheld due to previous submission). The carrier does not indicate what submission CPT code 20550-51 is a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$140.00 (although the requestor billed \$280.00 the table of disputed services only lists \$140.00 in dispute).

CPT code J3490 date of service 05-14-03 denied as a duplicate (reimbursement for procedure withheld due to previous submission). The carrier does not indicate what submission CPT code J3490 is a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$20.00.

HCPCS code A4550 date of service 05-14-03 denied as a duplicate (reimbursement for procedure withheld due to previous submission). The carrier does not indicate what submission HCPCS code A4550 is a duplicate to. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of \$45.00.

Review of CPT code 99361 (2 units) date of service 05-23-03 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOBs accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$106.00 (\$53.00 X 2 units).

CPT code 97039-59 dates of service 06-13-03 and 06-30-03 denied with denial code "F" (submitted documentation does not support or meet the criteria for one-on-one therapy that is identified in the Fee Guidelines Ground Rules and/or CPT code descriptor for reimbursement). Documentation submitted by the requestor supports the services billed. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$60.00 (\$30.00 X 2 DOS).

CPT code 99213-MP date of service 06-13-03 denied with denial code "F" (submitted documentation does not support or meet the criteria for one-on-one therapy that is identified in the Fee Guidelines Ground Rules and/or CPT code descriptor for reimbursement). Documentation submitted by the requestor supports the services billed. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$48.00.

CPT code 99213 date of service 10-16-03 denied with denial code "F" (reimbursement according to the Texas Medical Fee Guidelines). Additional reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$6.62 ($\$52.95 \times 125\% = \66.19 minus carrier payment of \$59.57).

Review of CPT code 97001 date of service 10-15-03 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOBs accordance with Rule 133.307(e)(2)(B) additional reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$9.41 ($\$75.29 \times 125\% = \94.11 minus carrier payment of \$84.70).

CPT code 97750 (8 units) date of service 10-15-03 denied with denial code "F" (FCE's are allowed a maximum of three times per injured worker per the medicine section, page 35 of the 04/01/96 Texas Fee Guidelines). Documentation submitted by the requestor does not support the services billed. No reimbursement recommended.

Review of CPT code 97150-59 dates of service 10-20-03 (2 units) and 10-22-03 (1 unit) revealed that neither the requestor nor the respondent submitted copies of EOBs. The requestor provided convincing evidence of carrier receipt of the providers request for EOBs in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$71.04 ($\$18.94 \times 125 = \23.68×3 units).

Review of CPT code 99090 date of service 10-24-03 revealed that neither the requestor nor the respondent submitted a copy of an EOB. The requestor provided convincing evidence of carrier receipt of the providers request for an EOB in accordance with Rule 133.307(e)(2)(B). Reimbursement is recommended in the amount of \$110.00.

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) and in accordance with Medicare program reimbursement methodologies effective 08-01-03 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 Decision is applicable for dates of service 01-15-03 through 10-24-03 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 Findings and Decision and Order are hereby issued this 23rd day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

May 3, 2004

Re: IRO Case # M5-04-1316-01
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ 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 ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ 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, 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 ___ 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 ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service 1/15/03 – 11/14/03
2. Explanation of benefits
3. Letter from Requestor to IRO 4/8/04
4. Medical records from treating DC 2001, 2002, 2003
5. MRI report lumbar spine 4/12/04
6. Electrodiagnostic study report 8/20/01
7. Discogram report 12/10/03
8. Reports and records and progress notes from other physicians
9. Report 12/7/01
10. Report 9/24/01
11. Report 2/27/02
12. Report 2/28/02
13. DDE report 1/11/02, 9/17/02
14. IME report 10/16/01
15. FCE 2/8/02, 7/5/02
16. PPE report 10/15/03
17. Treatment notes and progressive rehabilitation 10/15/03 – 11/26/03
18. Peer review 6/26/03
19. Case notes from treating D.C. 1/16/04 – 3/17/04
20. Reference material from treating D.C.

History

The patient injured her low back on ___ while pulling her luggage onto a plane. She felt sudden lower back pain. She has had numerous medical examinations and diagnostic tests, medications, injections, physical therapy, pain management treatment and chiropractic treatment.

Requested Service(s)

97039-59 unlisted modality, 99213 ov, 99361 med conf by physician, 97010-59 appl of modality hot or cold packs, 97014-59 elec stim unattended, 97112-59 neuromuscular reeducation, 97150-59 ther proc 1/15/03 – 11/14/03

Decision

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

Rationale

The patient received an extensive course of physical therapy prior to the dates in dispute without documented relief of her symptoms or improved function. The

patient's VAS on 11/6/03, after about 2 ½ years of treatment, was still 8/10. In reviewing all the daily notes from the treating D.C., the patient's VAS was 7-8/10 on a regular basis. The continued use of failed conservative treatment was unchanging. The patient's desire and effort to improve her condition is not clear. She failed to respond in any manner to treatment by several doctors. This is supported by a lack of objective, quantifiable findings. The findings that were noted were very inconsistent throughout treatment. Conservative treatment had failed to be beneficial. Treatment was over utilized and inappropriate, and possibly was iatrogenic, resulting in doctor dependency. The records suggest a lack of motivation to get well. The disputed treatment failed to help the patient and was not reasonable or necessary.

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