

MDR Tracking Number: M5-04-2503-01

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 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 4-9-04.

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 \$460** 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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute 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 6-30-04, 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.

The carrier denied CPT code 99080-73 for dates of service 4-28-03, 6-2-03 and 7-15-03 with a G for unbundling, however, per rule 129.5 the TWCC-73 is a required work status report. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 134.1(c) **recommend reimbursement of \$45.00.**

CPT code 97250 for dates of service 7-15-03, 7-16-03, 7-18-03, 7-23-04 and 7-28-03 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Carrier has made payment of \$177.75 for these dates of service. This data is shown in the graph below. **Recommend additional reimbursement of \$37.25 to fulfill the MAR of \$43.00 per unit.**

<u>CPT Code 97250</u>	<u>MAR</u>	<u>Paid</u>	<u>Balance</u>
7/15/2003	\$43.00	\$42.41	\$0.59
7/16/2003	\$43.00	\$42.41	\$0.59
7/18/2003	\$43.00	\$27.99	\$15.01
7/23/2003	\$43.00	\$32.47	\$10.53
7/28/2003	<u>\$43.00</u>	<u>\$32.47</u>	<u>\$10.53</u>
		\$177.75	\$37.25

CPT code 97265 for dates of service 7-15-03, 7-16-03, 7-18-03, 7-23-04 and 7-28-03 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Carrier has made payment of \$177.70 for these dates of service. This data is shown in the graph below. **Recommend additional reimbursement of \$37.30 to fulfill the MAR of \$43.00 per unit.**

<u>CPT Code 97265</u>	MAR	Paid	Balance
7/15/2003	\$43.00	\$42.41	\$0.59
7/16/2003	\$43.00	\$42.41	\$0.59
7/18/2003	\$43.00	\$27.99	\$15.01
7/23/2003	\$43.00	\$32.47	\$10.53
7/28/2003	<u>\$43.00</u>	<u>\$32.42</u>	<u>\$10.58</u>
	\$215.00	\$177.70	\$37.30

CPT code 99070 for dates of service 7-18-04, 9-12-03, 9-19-03, and 10-1-03 is a DOP code. Per Rule 133.307(g)(3)(D), the requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided no evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. **No additional reimbursement recommended.**

CPT code 97150 for dates of service 7-16-03, 7-18-03 and 7-23-04 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Carrier has made payment of \$64.59 for these dates of service. This data is shown in the graph below. **Recommend additional reimbursement of \$16.41 to fulfill the MAR of \$27.00 per unit.**

<u>CPT Code 97150</u>	MAR	Paid	Balance
7/23/2003	\$27.00	\$26.63	\$0.37
7/18/2003	\$27.00	\$17.57	\$9.43
7/23/2003	<u>\$27.00</u>	<u>\$20.39</u>	<u>\$6.61</u>
	\$81.00	\$64.59	\$16.41

CPT code 99213 for dates of service 7-23-04 and 7-28-03 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Carrier has made payment of \$75.50 for these dates of service. This data is shown in the graph below. **Recommend additional reimbursement of \$20.50 to fulfill the MAR of \$48.00 per unit.**

<u>CPT Code 99213</u>	MAR	Paid	Balance
7/23/2003	\$48.00	\$37.75	\$10.25
7/28/2003	<u>\$48.00</u>	<u>\$37.75</u>	<u>\$10.25</u>
	\$96.00	\$75.50	\$20.50

CPT code 97014 for dates of service 7-28-03 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Carrier has made payment of \$12.84 for this date of service. **Recommend additional reimbursement of \$2.16 to fulfill the MAR of \$15.00 per unit.**

CPT code 97750-MT for dates of service 8-21-03, 10-16-03 and 10-20-03 was partially paid by the respondent. Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge. Proof of delivery of service was submitted by the requester and no additional rationale was submitted. Carrier has made payment of \$100.21 for these dates of service. This data is shown in the graph below. **Recommend additional reimbursement of \$333.99 to fulfill the MAR of \$33.40 per unit.**

<u>Code 97750-MT</u>	MAR	Paid	Balance
8/21/2003	\$100.20	\$33.41	\$66.79
10/16/2003	\$100.20	\$33.40	\$200.40
10/20/2003	<u>\$100.20</u>	<u>\$33.40</u>	<u>\$66.80</u>
	\$300.60	\$100.21	\$333.99

CPT code 98943 for dates of service 9-16-03, 9-17-03, 9-19-03 and 10-13-03 was denied by the carrier with no denial code. This code reports a procedure, service or supply that is not covered or valid for Medicare. Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." **Reimbursement is not recommended.**

CPT code 95851 for date of service 8-21-03 was denied with a G. Per rule 133.304 (c) Carrier didn't specify which service this was global to, therefore it will be reviewed according to the Medicare Fee Schedule and reimburse requestor. **Reimbursement of \$33.40 is recommended.**

CPT code 99212 for dates of service 8-22-03, 8-29-03 and 9-24-03 was denied with an F or a G. HCFA's and proof of delivery of service were provided by the requester. Therefore, per rule 133.304 (c) as Carrier didn't specify which service this was global to, it will be reviewed according to the Medicare Fee Schedule. **Reimbursement of \$125.73 is recommended.**

CPT code 97110 for dates of service 10-17-03 was denied with an F. 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. **Additional reimbursement not recommended.**

CPT code 98940 on dates of service 10-10-03 was denied with an N. (Not appropriately documented.) Additional documentation which does support this service was received by the Commission on 7-19-04. **Recommend reimbursement of \$30.13.**

This Findings and Decision is hereby issued this 29<sup>th</sup> day of October 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 4-28-03 through 10-20-03 as outlined above:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- in accordance with Medicare program reimbursement methodologies for dates of service after 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.

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 29<sup>th</sup> day of October 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

June 1, 2004

David Martinez  
TWCC Medical Dispute Resolution  
7551 Metro Center Suite 100  
Austin, TX 78744

Patient:  
TWCC #:  
MDR Tracking #: M5-04-2503-01  
IRO #: 5284

Specialty IRO has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty IRO has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The Specialty IRO health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Specialty IRO for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ was injured on the job on \_\_\_. She sought treatment with Dr. I. She then sought treatment with Dr. B on 4/04/03. She underwent a course of passive modalities and active modalities until she had surgery on 8/4/03. She underwent another course of physical therapeutics through 10/17/03. (There was a gap in the records from 6/6/03 to 6/23/03 and 7/28/03 through 8/21/03; therefore, the reviewer requested that we obtain these records so that a proper review could be performed) These records were obtained via fax on 5/25/04 and passed on to the reviewer immediately via fax.

#### DISPUTED SERVICES

Were the muscle testing and therapeutic exercises medically necessary from 4/29/03 through 10/15/03.

#### DECISION

The reviewer disagrees with the previous adverse determination for all the services in question.

#### BASIS FOR THE DECISION

The reviewer indicates that all the services in question were properly documented, done on a one on basis per the documentation, complied with TWCC Guidelines, conformed to accepted treatment protocols (ACOEM Guidelines) and were medically necessary as defined by TLC 408.021. The carrier consistently paid for ½ of the requested services when it came to therapeutic exercises even though all units were documented. The muscle testing examinations were appropriate to assess the patient's improvement throughout treatment.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,