

MDR Tracking Number: M5-04-2524-01

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 1-23-04.

In accordance with Rule 133.308 (e), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date of service in dispute. The Commission received the medical dispute resolution request on 1-23-04, therefore the following date of service is not timely and are not eligible for this review: 1-22-03.

The requester has withdrawn several items from the table as these services were paid by the respondent. (CPT Code 99361 has been billed for several different doctors on the same date of service.) These services are CPT Code 99361 for 2-14-03; CPT Code 97545 and 97546 for 3-3-03 3-4-03, 3-5-03, 3-6-03 and 3-7-03; and CPT Code 99213 for 8-13-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that prolonged E & M service, level III and IV office visits w/manipulation, unlisted modality, muscle testing, hot-cold pack therapy and electrical stimulation-unattended from 1-28-03 through 9-23-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

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 8-9-04, 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.

CPT code 97545 for date of service 1-28-03 was billed by the requestor and denied by the carrier with an F denial code. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service. Reimbursement is at the non-CARF rate according to 134.202 (e)(5)(A)(i) at \$51.20 per hour.

Recommend reimbursement of \$102.40.

Regarding CPT Code 99358 for dates of service 2-1-03, 2-5-03, 2-7-03, 2-9-03, 2-18-03, 4-14-03, 6-23-03, 6-25-03, 11-5-03: Neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, 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. Reimbursement is recommended in the amount of \$524.00.

Regarding CPT Code 97039-59 for date of service 2-7-03: No EOB was sent by either party. This is a DOP code under the **96 Fee Guidelines**. Therefore, 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 not provided evidence that the fees billed are the same as that for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers.
Recommend no reimbursement.

Regarding CPT Code 97039-59 for dates of service 10-09-03, 11-5-03, 12-4-03 and 12-16-03: neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, 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). Reimbursement is recommended in the amount of \$60.40.

Regarding CPT code 99361 for dates of service 2-7-03 (2 instances), 2-14-03, 3-14-03 (2 instances), 3-21-03 (2 instances), 4-11-03 (2 instances), 4-18-03 (2 instances), 4-25-03 (2 instances), 5-23-03 (2 instances): Neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, 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). Reimbursement is recommended in the amount of \$795.00.

Regarding CPT Code 99358 for dates of service 9-3-03 and 9-15-03: This service was denied with a G denial. 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. Per Rule 134.202 (c) 6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decision, and values assigned for services involving similar work and resource commitments. Reimbursement is recommended.

CPT Code 99361 for date of service 9-15-03 was denied with a G denial. 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. Per Rule 134.202 (c) 6) for products

and services for which CMS or the commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decision, and values assigned for services involving similar work and resource commitments. **Reimbursement is recommended.**

Regarding CPT Code 99213 for dates of service 2-12-03, 3-31-03, 10-09-03, 12-04-03 and 12-16-03 neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Since the carrier did not provide a valid basis for the denial of this service, 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). Reimbursement is recommended in the amount of \$294.57.

CPT Code A4558 on 4-8-03 was denied by the carrier with an F code. This is a DOP code. Therefore, 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 not provided evidence that the fees billed are the same as similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no reimbursement.

CPT Code A4556 on 4-8-03 was denied by the carrier with an F code. This is a DOP code. Therefore, 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 not provided evidence that the fees billed are the same as similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. Recommend no reimbursement.

The carrier denied CPT Code 99080-73 on 4-8-03 with an F denial code. However, the TWCC-73 is a required 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 \$15.00.**

Regarding CPT code G0283 for dates of service 8-6-03, 8-20-03, 8-27-03, 9-3-03, 9-23-03, 10-9-03, 11-5-03, 12-4-03 and 12-16-03: Neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. Reimbursement is recommended in the amount of \$149.67.

Regarding CPT Code 97545-WH and 97546-WH for date of service 9-5-03: Neither party submitted EOB's for these dates of service and did not timely respond to the request for additional information. Therefore, these dates of service will be reviewed in accordance with Rule 134.202. **Recommend reimbursement of \$307.20.**

Regarding CPT Code 99215 for 11-20-03: Neither party submitted EOB's for this date of service and did not timely respond to the request for additional information.

Therefore, these dates of service will be reviewed in accordance with Rule 134.202.

Recommend reimbursement of \$150.83.

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 1-28-03 through 12-16-03 as outlined above in this dispute:

- 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 Decision and Order is hereby issued this 2nd day of November 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

June 25, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2524-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, FCE, radiology report and designated doctor report.

Information provided by Respondent: designated doctor reports.

Information provided by Orthopedic Surgeon: office notes, electrodiagnostic test and radiology report.

Information provided by PhyMed/Rehab physician: office notes & FCE.

Clinical History:

The patient sustained a compensable back injury during the course and scope of his employment on ___. The worker received appropriate exigent medical services, medical non-surgical management, advanced invasive medical pain management, and physical therapy services. Diagnostic imaging corroborated the presence of a multilevel lumbar herniated nucleus pulposus, for which this individual declined his surgical option. The worker changed doctors and sought chiropractic services from the treating chiropractor beginning May of 2002. A Commission appointed designated doctor determined the worker's condition had reached maximum medical improvement no later than 01/15/03. Disposition assessed 5% whole person impairment associated with the worker's compensable injury. Notwithstanding the designated doctor's determination, the treating chiropractor continued to provide services that were not documented as medically necessary services.

Disputed Services:

Prolonged E&M service, level III & IV office visits w/manipulation, unlisted modality, muscle testing, hot/cold pack therapy and electrical stimulation-unattended during the period of 01/28/03 through 09/23/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above was not medically necessary in this case.

Rationale:

A duly licensed medical physician appointed by the Texas Worker's Compensation Commission as designated doctor determined the claimant's back condition was stable by 01/15/03. Disposition further indicated that without surgery, the injured employee's condition had reached maximum medical improvement. In affect, the designated doctor indicated that further material recovery from or lasting improvement to this individual's injury could no longer reasonably be anticipated based on reasonable medical probability.

The Act provides the injured worker is entitled to all healthcare reasonably required by the nature of his injury as and when needed. These services must be documented as medically necessary services and supported as such by the clinical documentation submitted by the treating doctor. Medical necessity supportive documentation must relate how the recommended services treat the diagnosis, promote recovery, or enhance the ability of the employee to return to or retain employment (Rule No. 134.500). The clinical documentation submitted by the treating chiropractor failed to substantiate the medical necessity of the services in question.

Sincerely,