

MDR Tracking Number: M5-04-2916-01

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. The dispute was received on 5-6-04.

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.

The therapeutic exercises, aquatic therapy, electrical stimulation unattended, myofascial release, joint mobilization, neuromuscular re-education and manual therapy technique from 07-03-03 through 9-2-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The therapeutic exercises, aquatic therapy, electrical stimulation unattended, myofascial release, joint mobilization, neuromuscular re-education and manual therapy technique from 9-2-03 through 10-28-03 **were not** found to be medically necessary.

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 6-29-04 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.

- Regarding CPT Code 99204 for date of service 7-10-03. The carrier denied this service for "F". Review of the recon HCFA reflected proof of submission. Rule 133.304 (c) states "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further

description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. Therefore, the disputed service or services will be reviewed according to the fee guidelines. (Medicare or 96 Fee Guideline.) **Recommend reimbursement of \$106.**

- No EOB's were submitted by either the requester or respondent for CPT Code 97110 on dates of service 9-9-03, 9-16-03, 9-18-03, 9-23-03, 9-25-03, 10-2-03, 10-7-03, 10-9-03, or 10-14-03. 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. **Reimbursement not recommended.**
- CPT Code 97113 for 2 units each on dates of service 9-9-03, 9-11-03, 9-23-03, 9-25-03, 10-7-03, and 10-9-03 was billed by the requestor and denied by the carrier. However, the carrier did not submit EOB's with respect to this code, and did not timely respond to the request for additional information. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended according to the MAR in the amount of \$420.53.**
- CPT Code 97140 for dates of service 10-2-03 and 10-9-03 was billed by the requestor and denied by the carrier. However, the carrier did not submit EOB's with respect to this code, and did not timely respond to the request for additional information. Since the carrier did not provide a valid basis for the denial of this service, **reimbursement is recommended according to the MAR in the amount of \$67.80.**

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

This Findings and Decision is hereby issued this 5th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Pursuant to 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) 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 (b);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 7-10-03 through 10-28-03 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 Order is hereby issued this 5th day of October, 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

DRM/da

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NOTICE OF INDEPENDENT REVIEW DECISION

July 22, 2004

Re: IRO Case # M5-04-2916

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 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 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 service 2/27/03 – 7/8/03
2. Explanation of benefits
3. Letter to TWCC 5/14/04
4. Reports 11/11/03, 3/12/03
5. TWCC work status reports
6. Letter 2/2/03
7. Report 1/22/03
8. Work releases
9. Attending physician's statements
10. TWCC notice of injury
11. TWCC request to change treating doctors 4/11/03
12. Occupational therapy records
13. Exercise flow sheets
14. Electrodiagnostic report 7/1/03
15. Report 7/10/03
16. Computerized ROM exam reports
17. D.C. treatment notes
18. Preauthorization for pain management
19. Medical necessity transportation reports
20. Denial for psychotherapy
21. Report 10/8/03
22. Letter of medical necessity 10/23/03
23. Letter re stimulator unit 11/7/03
24. TWCC-69 forms

25. Report 12/5/03

26. Request for reconsideration 9/8/03

History

The patient injured her mid and low back in ____ while carrying three fur coats to a customer. She initially saw an M.D. for treatment, and then sought chiropractic treatment. An MRI and x-rays were obtained. The patient was treated with medication, chiropractic treatment, aquatic therapy and physical therapy.

Requested Service(s)

Therapeutic exercise, aquatic therapy, elec stim unattend, myofascial release, joint mobilization, neuromuscular re education, manual therapy technique 7/3/03 – 10/28/03

Decision

I disagree with the carrier's decision to deny the requested services through 9/2/03
I agree with the decision to deny the requested services after 9/2/03.

Rationale

The patient reportedly had chiropractic treatment prior to the dates in dispute. No chiropractic treatment notes were provided for services prior to the dates in dispute, so I do not know how much treatment the patient had, or what form of treatment she received, or her response to treatment. Based on the records that were provided, it appears that the patient did respond to treatment initially, stating that she was "getting back to her old self." Based on the documentation provided, objective findings and subjective complaints supported treatment through 9/2/03. After this date, there was no change in the patient's VAS rating, and no change in objective findings. The treatment failed to be beneficial after 9/2/03. This was about eight months post injury, and the patient's response to any treatment had plateaued. The patient did have frequent flare ups necessitating extended costly treatment. Based on the records provided, the patient should have been on a home exercise program under the direction of her medical doctor, with medication to increase bone density and decrease pain. Supervised therapy was not necessary past 9/2/03.

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