MDR Tracking Number: M5-04-3269-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 5-27-04.

The IRO reviewed office visits, therapeutic exercises, ultrasound, electrical stimulation, hot/cold packs, myofascial release, group therapeutic procedures, manual therapy technique, neuromuscular re-education, and paraffin bath on 6-18-03 through 1-22-04.

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-15-04, 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.

Codes 99214 and J2000 were billed for date of service 11-11-03 and denied as "G, U454 – this office visit is included in the value of the surgery or anesthesia procedure." And "G, X006 – local infiltration, digital block or topical anesthesia is included in the value of the surgery procedure." Surgical procedure (20553) billed on 11-11-03 was paid by the carrier.

- Per Ingenix CCI edits, the office visit is not global. Recommend reimbursement of $73.84 x 125% = $92.30.
- Per Ingenix CCI edits, J2000 is global to 20553; therefore, no reimbursement recommended.

HCPCS code A4209 billed for date of service 11-11-03 was denied as "F – the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix". Per the EOB, the carrier paid $0.53. The requestor did not submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement as required by Rule 133.307(g)(3)(D); therefore, no additional reimbursement is recommended.

Codes 97140 and 97035 were billed on date of service 11-24-03. Requestor states they did not receive payment. Per the EOB dated 12-22-03, the carrier issued a check #05509945 on 12-23-03. Therefore, no dispute exists.

Code 99499-RR (as listed on the table of disputed services) billed on date of service 1-6-04 should be 99455-VR as listed on the HCFA and verified with the requestor on 7-14-04. The EOB addresses code 99499-RR. Therefore, the correct code 99455-VR had no EOB submitted by either party. Daily note indicates that the requestor (treating doctor), reviewed the designated doctor report. Per Rule 134.202 (e)(6)(F), recommend reimbursement of $50.00.

Code 99090 billed for date of service 1-19-04 was denied as "G, B377 – this is a bundled procedure; no separate payment allowed." The carrier did not indicate what this code is bundled to. However, no reimbursement can be recommended since the daily note does not support analysis of clinical data stored in computers.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or 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.

This Order is applicable to dates of service 11-11-03 and 1-6-04 as outlined above 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 19th day of January 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Envoy Medical Systems, LP

1726 Cricket Hollow
Austin, Texas 78758

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

NOTICE OF INDEPENDENT REVIEW DECISION

September 22, 2004

Re: IRO Case # M5-04-3269 amended 10/26/04

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, 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 physician who is board Certified in Orthopedic Surgery, 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 services
2. Explanation of benefits
3. Impairment rating
4. Chiropractic modality review
5. Letter of reconsideration
6. Retrospective record review
7. Multiple notes from treatment provider
8. EMG report
9. Pain management records
10. Neurologist records
11. X-ray reports
12. Treatment logs
13. Prescriptions
14. Work status reports
15. FCE 1/13/04
16. Occupational therapy evaluation

History

The patient is a 33-year-old female who reported neck and bilateral arm pain in ___, which she felt was related to repetitive activities at work. The upper extremity symptoms started in the left, followed by the right. The patient has had extensive nerve testing, MRIs and x-rays. She initially was placed on limited disability, then was deemed to be totally disabled. The patient had extensive physical therapy in 2002 and 2003. Eventually she had surgery for thoracic outlet syndrome, with a first rib resection. The patient's nerve studies improved, and she underwent right carpal tunnel release surgery on 10/14/03. The patient also had multiple cervical epidural steroid injections in the C6-7 area after a herniated disk was seen on MRI. Spine surgical consultation was obtained, and initially diskectomy was recommended, but this was changed to the recommendation of thoracic outlet evaluation and surgery. The patient has not undergone neck surgery.

Requested Service(s)
Office visits, therapeutic exercises, ultrasound therapy, electrical stimulation, hot/cold pack therapy, myofascial release, group therapeutic procedures, manual therapy technique, neuromuscular reeducation, paraffin bath. 6/18/03 – 1/22/04

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

Rationale
The patient had received extensive physical therapy prior to the dates in dispute for her condition, and could have performed exercises in a home exercise program. The vast majority of the sessions in dispute, including modalities, represented post injection therapy. Post injection therapy is not an accepted modality for treatment, especially when the patient already had received extensive therapy for the same condition.
Based on the documentation, an office visit was appropriate to reviw the patient's functional capacity evaluation of 1/13/04.

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