

MDR Tracking Number: M5-04-3777-01

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 7-2-04.

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 office visits from 7-30-03 through 8-29-03 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 9-3-04, 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 97010 for date of service 7-30-03 was billed by the requestor and denied by the carrier. This service was denied with an "F" by the carrier. Since the carrier did not provide a valid basis for the denial of this service, it will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$11.00.**
- Regarding CPT Code 97014 for date of service 7-30-03 was billed by the requestor and denied by the carrier. This service was denied with an "F" by the carrier. Since the carrier did not provide a valid basis for the denial of this service, it will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$15.00.**
- Regarding CPT Code 97035 for date of service 7-30-03 was billed by the requestor and denied by the carrier. This service was denied with an "F" by the carrier. Since the carrier did not provide a valid basis for the denial of this service, it will be reviewed in accordance with the 1996 Medical Fee Guidelines. **Reimbursement is recommended in the amount of \$22.00.**
- Regarding CPT Code 97010 for dates of service 8-6-03, 8-7-03, 8-13-03, 8-19-03, 8-20-03, 8-25-03 and 8-29-03 was billed by the requestor and denied by the carrier with a "G" denial code. According to the Medicare CCI edits, this CPT code is considered bundled to physical therapy. **No reimbursement is recommended.**

- Regarding CPT Code G0283 for dates of service 8-6-03, 8-7-03, 8-13-03, 8-19-03, 8-20-03, 8-25-03 and 8-29-03 was billed by the requestor and denied by the carrier with a “G” denial code. Since the carrier did not provide a valid basis for the denial of this service, it will be reviewed in accordance with the Medicare Fee Guidelines. **Reimbursement is recommended in the amount of \$104.37.**
- Regarding CPT Code 97035 for dates of service 8-6-03, 8-7-03, 8-13-03, 8-19-03, 8-20-03, 8-25-03 and 8-29-03 was billed by the requestor and denied by the carrier with an “F” denial code. Since the carrier did not provide a valid basis for the denial of this service, it will be reviewed in accordance with the Medicare Fee Guidelines. **Reimbursement is recommended in the amount of \$99.47.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees from 7-30-03 through 8-29-03 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 Decision and Order is hereby issued this 20th day of October 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division

August 24, 2004

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

Re: Medical Dispute Resolution

MDR #: M5-04-3777-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ 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: office notes, treatment logs, clinical interview, rehab notes, prescription, radiology, FCE/PPE.

Clinical History:

The claimant is a 49-year-old male who was injured in a work-related accident on ___, at which time he jammed knees. There is no forwarded medical record regarding medical attention until the claimant consulted a chiropractor on 97/28/03. The claimant was diagnosed with a possible medial meniscal tear of the anterior horn of the left knee. The worker was taken off of work pending MR imaging and orthopaedic consult. Radiographic series of the left knee performed 07/28/03 revealed that the claimant had a spur of the anterior and superior margin of the patella. A course of passive/active rehabilitation was implemented at the direction of the chiropractor.

Disputed Services:

Office visits during the period of 07/30/03 through 08/29/03.

Decision:

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

Rationale:

The provider is not in any capacity to establish physician medical necessity for implementing office visit codes while performing rehabilitation over the claimant's left knee. There is no data to support any application of office visit codes in the management of this claimant's condition from 07/30/03 through 08/29/03. The record reviewed showed that a referral to Dr. W (orthopaedist) was attempted, but no other clear rationale exists to warrant the provider's utilization of office visits coupled with physical therapy applications.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- *Knee*. Work Loss Data Institute; 2003.46p.
- *Overview of Implementation of Outcome Assessment Case Management In The Clinical Practice*. Washington State Chiropractic Association; 2001, 54p.

Sincerely,