

MDR Tracking Number: M5-04-3904-01

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, 133.307 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 07-14-04.

The IRO reviewed muscle testing on date of service 08-12-03 and 09-09-03 and office visits on 09-24-03 and 10-31-03 that were denied based upon "U".

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.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** 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 12-16-04, 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 99213 date of service 08-11-03 denied with denial code "F/MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). Per Rule 133.304(c) the carrier did not specify which service code 99213 was global to, therefore the service is reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$59.00 (\$47.20 X 125%).

CPT code 99213 dates of service 08-13-03 and 08-18-03 denied with denial code "F" (charge exceeds the amount indicated in the fee schedule. The carrier made no payment. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$118.00 (\$47.20 X 125% = \$59.00 X 2 DOS).

CPT code 99213 dates of service 08-27-03, 09-03-03, 09-08-03 and 09-09-03 denied with denial code "N" (not appropriately documented). The requestor did not provide documentation for review. No reimbursement recommended.

CPT code 99213 date of service 08-29-03 per the respondent's EOB has been paid. The requestor was contacted and payment was verified. Therefore this service is no longer in dispute.

CPT code 97140 date of service 08-29-03 denied with denial code "F/MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). Per Rule 133.304(c) the carrier did not specify which service code 97140 was global to, therefore the service is reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.90 (\$24.72 X 125%).

CPT code 97035 date of service 08-29-03 denied with denial code "F/MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). Per Rule 133.304(c) the carrier did not specify which service code 97035 was global to, therefore the service is reviewed according to the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$14.22 (\$11.37 X 125%).

CPT code G0283 date of service 09-09-03 denied with denial code "NC" (a service has been billed for which a payment is not allowed). The carrier has made no payment. The EOB indicates the billed service as CPT code 97014 which was invalid after 08-01-03. The billed service was CPT code G0283 which is

valid. Reimbursement is recommended per the Medicare Fee Schedule in the amount of \$14.91 (\$11.93 X 125%).

CPT code 99080-73 date of service 10-27-03 denied with denial code "F/TD" (the work status report was not properly completed or was submitted in excess of the filing requirements). The requestor did not submit documentation for review. No reimbursement recommended.

HCPCS code L3908 date of service 11-06-03 denied with denial code "MD" (a valid modifier is required for this service). Per the Medicare DMEPOS 2003 Fee Schedule no modifier is required. Reimbursement is recommended in the amount of \$55.18 (\$44.14 X 125%).

CPT code 99214 date of service 11-06-03 denied with denial code "N" (not appropriately documented). The requestor did not provide documentation for review. No reimbursement recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies effective 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 Decision is applicable for dates of service 8-28-01 through 12-28-01 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 Findings and Decision and Order are hereby issued this 5th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 27, 2004

RE:

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IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating 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 the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- 26 physical therapy notes from 7/30/03 through 6/3/04
- Table of disputed services and explanation of benefits pages accompanied by the usual IRO documentation
- Several subsequent follow up chiropractic narrative reports dated 7/29/03, 8/22/03, 9/22/03, 10/27/03, 2/24/04, 4/26/04, 7/8/04 and 7/28/04
- Several TWCC-73 reports from _____ dated 7/29/03, 8/22/03, 9/22/03, 10/27/03, 2/24/04, 3/17/04, 4/26/04, 7/8/04 and 7/28/04
- Several visits from _____ in _____ office, dated 10/31/03, 1/13/04, 5/4/04 and 5/26/04
- Occupational therapy/testing prescription dated 1/13/04 for post injection physical therapy regarding bilateral trapezius trigger point injections
- Electrodiagnostic study report from _____ of 9/16/03 showing only the presence of mild bilateral carpal tunnel syndrome
- Several follow up visit reports from _____ dated 10/28/03 and 11/24/03
- Occupational therapy/testing prescription dated 5/4/04 for post trigger point injection therapy
- 9/16/03 prescription from an unknown provider, which may have been _____, stating the claimant needed bilateral carpal tunnel syndrome splints
- Undated prescription from _____ recommending orthopedic consultation for the right elbow – the date of this was probably 10/31/03 which correlated with the office visit of that same date regarding the same issue
- Narrative summaries and follow up reports from _____, neurologist, dated 9/9/03 and 10/9/03
- Two notes from _____ dated 10/16/03 and 11/6/03
- Prescription from _____ for bilateral cock up splints – the date of this prescription is difficult to decipher
- IME supplemental report dated 1/30/04 from _____ recommending that the only reasonable future medical for this claimant was probably an anterior cervical discectomy at C4/5 with instrumentation
- Two physical performance evaluations including range of motion and strength evaluations dated 8/12/03 and 9/9/03
- 10/30/03 note from _____.
- Several TWCC-73 reports from _____ dated 10/30/03, 11/13/03, 3/4/04 and 7/1/04
- Prescription from _____ dated 9/9/03 recommending an MRI of the cervical and lumbar spine
- Several upper extremity evaluation reports from _____ dated 7/1/04, 3/4/04 and 11/13/03

- Initial examination report and follow up visit with _____ dated 3/26/04 and 7/30/04
- Several MRI and x-ray reports to include right elbow x-ray report dated 7/30/03, lumbar spine x-ray report dated 7/30/03, cervical spine x-ray report dated 7/30/03, MRI of the right elbow report dated 8/26/03, MRI of the lumbar spine dated 9/18/03 and cervical spine MRI report dated 9/18/03

Submitted by Respondent:

- None received

Clinical History

According to the documentation submitted for review, the claimant was walking on some wood planks along a flatbed trailer when he fell through some of the rotten boards causing his left leg to go through with his right leg extended or outstretched. The claimant also struck his right elbow on the way down and he appeared to scrape or contuse his back as well. The claimant's head or neck more or less whipped backwards during the process. The initial chiropractic exam of 7/29/03 revealed diagnoses of right sacroiliac joint strain, lumbar sprain/strain, possible chip fracture at the elbow olecranon, right sided cervical sprain/strain, and left anterior rib strain involving the 2nd through 4th or 5th ribs. The claimant underwent the usual chiropractic care and physical therapy which technically began on 7/30/03. The claimant underwent electrodiagnostic studies and the only finding was bilateral carpal tunnel syndrome which would not likely be related to the injury. It was felt the claimant had cubital tunnel syndrome as well; however, this was reportedly negative on electrodiagnostic testing. _____ did feel the only reasonable option for this claimant would be an anterior cervical discectomy at C4/5; however, _____ did state the claimant had significant evidence of symptom magnification. The claimant saw numerous physicians, who were all working at Neuromuscular Institute.

Requested Service(s)

Muscle testing (97750-MT) on 8/12/03 and 9/9/03; office visits (99213, 99202) on 9/24/03 and 10/31/03. Although there is a range of disputed services provided in the documentation which run from 8/11/03 through 11/6/03, I have been specifically asked to address the 2 muscle testing dates of service as well as the 2 office visits of 9/24/03 and 10/31/03.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary.

Rationale/Basis for Decision

As far as the office visit of 10/31/03 is concerned, the claimant saw a PA on this date for initial exam and it was revealed that the PA worked in the same office as the numerous other physicians whom the claimant saw. There was no need to bill for an initial office visit as this more represented a subsequent follow up office visit even if it was with a new provider within the same office, therefore I do not see the medical necessity of this particular code of 99202

being billed. As far as the office visit of 9/24/03 is concerned, there is nothing in the documentation provided for review which separated this visit from any of the other physical therapy visits. The only 9/24/03 date of service consists of a 9/24/03 physical therapy note which is no different than any of the other physical therapy notes therefore the documentation rule has not been fulfilled as this office visit was no different than any other office visits which occurred and there is lack of documentation to support the billing of the office visit on that date. Nothing distinct or different occurred on this visit as it was an ordinary physical therapy visit which occurred on 9/24/03. As far as the muscle testing evaluations of 8/12/03 and 9/9/03 are concerned, I do feel that some testing would be appropriate in order to get a baseline of how the claimant was doing; however, the first muscle test or physical performance evaluation visit took place on 8/12/03 after 4 visits of physical therapy when the claimant's pain levels were obviously high. The claimant's condition at that time would have prevented him from performing well on the test and there is no logic really to support the need for a physical performance evaluation only 4 days into treatment. The next physical performance evaluation visit took place on 9/9/03, only 13-14 visits into the physical therapy program when the claimant's pain levels were obviously still high. It certainly would not be expected that the claimant would perform well and I saw no need or medical necessity for this particular service on this particular date. The purpose of the testing and the timing was not really specified or appropriate. The claimant's progress was obviously documented to be slow and he was awaiting further diagnostic testing. Therefore, I saw no medical necessity established for the physical performance evaluation testing of either date listed in the dispute. There was no desire to return the claimant to work at this early time and this would be another reason for the test to not be medically necessary. The testing occurred after the 4th visit and after the 13th or 14th visit and there was obviously minimal change in the claimant's condition through the regular physical therapy evaluation and follow up visits. If this was indeed the case, then there would be no need for testing to confirm the obvious. The testing also, in my opinion, did not enhance or contribute to the claimant's treatment plan at that time because he was in the process of undergoing further diagnostic work ups and referrals for injections. The testing really served no purpose from a diagnostic or prognostic point of view.