MDR Tracking Number: M5-04-3986-01

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 7-21-04.

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 the office consultation, motor nerve conduction tests, sensory nerve test and muscle tests – 2 limbs, for 10-06-03 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 8-18-04, 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 97110 for all dates of service: 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. **Additional reimbursement not recommended.**

- CPT Code 97139 for dates of service 7-21-03, 7-23-03, 7-25-03, 8-4-03, 8-11-03, 8-25-03, 8-27-03, 9-15-03, and 10-8-03 was denied by the carrier with an N- not appropriately documented. The requester has not submitted additional information to verify these services. **No reimbursement recommended.**

- CPT Code 98940 for dates of service 8-4-03, 8-18-03, 8-25-03, 8-27-03, 9-15-03, 9-23-03, 9-25-03, 9-29-03 and 10-6-03 was denied by the carrier with an N- not appropriately documented. The requester has submitted additional documentation to support the services as billed. **Recommend reimbursement of $297.72. ($33.08 x 9)**

- CPT Code 97140-59 for dates of service 8-4-03, 8-11-03, 8-18-03 (2 units), 8-25-03 and 10-8-03 was denied by the carrier with an N- not appropriately documented. The requester has submitted additional documentation to support the services as billed. **Recommend reimbursement of $204.30. ($34.05 x 6)**

- CPT Code 97140-59 for dates of service 12-19-03 was denied by the carrier with an L – not Treating Doctor approved. However, Dr. Syvrud submitted documentation that shows he allows any doctor associated with the clinic to treat this patient. **Recommend reimbursement of $34.05.**

- CPT Code 97140-59 for dates of service 1-2-04, 1-6-04, 1-8-04, 1-12-04, 1-21-04, was partially paid by the carrier. The MAR is $34.13 and the carrier paid $34.05. Per 134.202(c)(1) **Recommend additional reimbursement of $.40. ($.08 x 5)**

- CPT Code 97016 for dates of service 8-4-03, 8-11-03, 8-25-03, 8-27-03, 9-15-03, 10-8-03, 11-19-03 was denied by the carrier with an N- not appropriately documented or no EOB was provided. The requester has submitted additional documentation to verify these services were delivered. **Recommend reimbursement of $121.52. ($17.36 x 8)**

- CPT Code 97016 for dates of service 1-2-04, 1-6-04, 1-8-04 and 1-21-04, was partially paid by the carrier. The MAR is $18.40 and the carrier paid $18.09. Per 134.202(c)(1): "For service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the TWCC system is the effective conversion factor adopted by CMS multiplied by 125%". **Recommend additional reimbursement of 1.24. ($.31 x 4)**

- CPT Code 97012 for dates of service 8-4-03, 8-18-03, 8-25-03, 8-27-03, 9-15-03, 9-23-03, 9-25-03, 9-29-03, 10-6-03, 10-8-03 and 11-19-03 was denied by the carrier with an N- not appropriately documented or no EOB was provided. The requester has submitted additional documentation to verify these services. **Recommend reimbursement of $207.90. ($18.90 x 11)**

- CPT Code 98943 for dates of service 8-18-03 - 8-25-03 was denied by the carrier with an N- not appropriately documented. This is not a valid code under the Medicare Fee Schedule and per the General Instructions is not reimbursable.

- CPT Code 97010 for dates of service 9-23-03, 9-25-03, 9-29-03 and 10-8-03 was denied by the carrier with an N- not appropriately documented or no EOB was provided. The requester has submitted additional documentation to verify these services. **Recommend reimbursement according Medicare Fee Schedule. ($11.00 x 4)**

- Regarding CPT Code 99070 for 10-6-03 – there was no EOB provided. However, the doctor's notes make no mention of these supplies and there is no evidence that this service was delivered. **Recommend no reimbursement.**

- Regarding CPT Code 97139 for date of service 11-19-03 – Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). The requester has not submitted additional information to verify these services. **No reimbursement recommended.**

- Regarding CPT Code 98941 for date of service 11-19-03 – Neither party submitted EOB's for these dates of services (and did not timely respond to the request for additional information). Therefore, this date 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, **reimbursement is recommended in the amount of $45.00.**

- CPT Code 98940 for dates of service 1-12-04, was partially paid by the carrier. The MAR is $33.61 and the carrier paid $33.08. Per 134.202(c)(1): "For service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the TWCC system is the effective conversion factor adopted by CMS multiplied by 125%". **Recommend additional reimbursement of $.53.**

- CPT Code 97750 for date of service 1-15-04 was partially paid by the carrier. The MAR is $185.25 and the carrier paid $147.76. Per 134.202(c)(1): "For service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the TWCC system is the effective conversion factor adopted by CMS multiplied by 125%". **Recommend additional reimbursement of $37.49.**

- CPT Code 97035 for date of service 1-21-04 was partially paid by the carrier. The MAR is $15.84 and the carrier paid $15.56. Per 134.202(c)(1): "For service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the TWCC system is the effective conversion factor adopted by CMS multiplied by 125%". **Recommend additional reimbursement of $.28.**

- CPT Code 97012 for date of service 1-21-04 was partially paid by the carrier. The MAR is $19.21 and the carrier paid $18.90. Per 134.202(c)(1): "For service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the TWCC system is the effective conversion factor adopted by CMS multiplied by 125%". **Recommend additional reimbursement of $.31.**

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 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. . This Decision is applicable for dates of service 8-4-03 through 1-21-04 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 Decision and Order is hereby issued this 2nd day of December 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

September 22, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3986-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 49 year-old female injured her neck, right arm, and right elbow on ___ while performing her job doing repetitive overhead lifting. Her diagnoses are cervical radiculopathy, tendonitis of the right elbow and of the right shoulder and cervical sprain/strain and right shoulder sprain/strain. She has been treated with therapy, medications and epidural steroid injections.

Requested Service(s)

Office consult (99243), motor nerve conduction tests (95903/95900), sensory nerve test (95904) and muscle tests-2 limbs (95861) for date of service 10/06/03.

Decision

It is determined that the office consult, motor nerve conduction tests, sensory nerve test and muscle tests-2 limbs for date of service 10/06/04 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based on the medical record documentation provided, it appears that the claimant was referred for neurodiagnostic testing on 09/29/03. However, there is no comprehensive evaluation or consultation reflected in the documentation for either date of service 09/29/03 or for 10/06/03 to warrant the examination in question. There is insufficient information contained in the documentation to substantiate the utilization of the nerve conduction and sensory nerve tests. Although the daily notes reference some lingering upper extremity symptoms, there is no documentation of significant neurological symptomatology present to warrant these tests. There is no documentation to support any significant observed or reported muscle weakness, present or suspected, to substantiate the need for the muscle testing. In addition, the results of the muscle testing are included in the documentation provided. Therefore the office consult, motor nerve conduction tests, sensory nerve test and muscle tests-2 limbs for date of service 10/06/03 were not medically necessary to treat this patient's condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-04-3986-01

<u>Information Submitted by Requestor:</u>

- Letter of Medical Necessity
- Progress Notes
- MRI
- Nerve Conduction Test
- Consult
- Epidural Injection

Information Submitted by Respondent: