

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 07-26-04.

The IRO reviewed electric stimulation, ultrasound, therapeutic exercises and therapeutic activities rendered from 11-04-03 through 12-10-03 that were denied based upon "U".

The IRO determined that the electrical stimulation (97032) and ultrasound (97035) from 11-04-03 through 12-03-03 **were** medically necessary. The IRO determined that the therapeutic exercises (97110) and therapeutic procedures (97530) from 11-04-03 through 12-03-03 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

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 08-23-04, 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 97032 date of service 11-05-03 denied with denial code "K" (not applicable healthcare provider). The provider billing for this service is on the TWCC approved doctor list. The denial code is invalid. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$18.83 (\$15.06 X 125%).

CPT code 97035 date of service 11-05-03 denied with denial code "K" (not applicable healthcare provider). The provider billing for this service is on the TWCC approved doctor list. The denial code is invalid. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$14.21 (\$11.27 X 125%).

CPT code 97110 date of service 11-05-03 denied with denial code "K" (not applicable healthcare provider). 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.

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 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 Decision is applicable for dates of service 11-04-03 through 12-10-03 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 Findings and Decision and Order are hereby issued this 3rd day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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NOTICE OF INDEPENDENT REVIEW DECISION

November 8, 2004

Re: IRO Case # M5-04-4043

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 Physical medicine and Rehabilitation, 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 4/21/03 – 5/20/03
2. Explanation of benefits
3. M.D. clinical note 11/3/03
4. FCE 11/11/03
5. Physiotherapeutic notes 11/4/03 – 12/10/03
6. Hospital ER records
7. X-ray reports lumbar and thoracic spine 10/7/03
8. Daily notes reports 11/3/03 –12/10/03

History

The patient was bending over and lifting a 60 pound large trash bag out of a trash can when he felt the acute onset of shooting pain through his shoulders, left arm, low back and left

hip. He continued to work with pain. On 10/7/03 he went to an emergency room. X-rays were taken of the mid and low back and were reported as essentially unremarkable. He was initially treated with muscle relaxants and pain medication. He followed up with his M.D. on 11/3/03, and was started on physical therapy on 11/4/03. An FCE on 11/11/03 indicated that the patient was capable of performing sedentary activities for limited periods of time. He was continued in physical therapy to 12/10/03. Some of the physical therapy charges were paid by the carrier.

Requested Service(s)

Electric stimulation 97032, ultrasound 97035, therapy exercises 97110, therap activities 97530 11/4/03 through 12/10/03

Decision

I disagree with the carrier's decision to deny the requested services codes 97032 and 97035 11/4/03 – 12/3/03.

I agree with the decision to deny the remainder of the requested services.

Rationale

The patient injured his back, and continued to work despite the pain. He followed up with his M.D., and was evaluated and found to have pain and muscle spasms in the thoracic spine. No diagnosis was given in the office note provided for this review. He was started on physical therapy consisting of modalities and exercises. This course of treatment is appropriate for what appears to be a thoracic sprain. Physical therapy three times per week for four weeks for 60-75 minutes per session, including those modalities and exercises, would be medically necessary and appropriate treatment for this type of injury. The documentation provided for this review does not support any medical necessity for therapy beyond this time period or length of time per session.

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