

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-4231.M5

MDR Tracking Number: M5-04-4112-01

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 08-03-04.

The IRO reviewed neuromuscular re-education, therapeutic exercises, therapeutic activities, manual therapy, gait training and office visits/outpatient rendered from 08-25-03 through 12-17-03 that were denied based upon "U".

The IRO determined that one hour of physical therapy (97110) per session from 10-07-03 through 11-21-03 **was** medically necessary. The IRO determined that all other services requested for review **were not** medically necessary.

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 08-30-04, 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 97530 (13 units) dates of service 10-20-03, 10-24-03, 10-27-03, 10-29-03, 10-31-03 and 11-03-03 denied with denial code "F/01" (the charge for the procedure exceeds the amount indicated in the fee schedule). The carrier has paid \$230.72 (7 units). Per Rule 134.202(b) reimbursement is recommended per the Medicare Fee Schedule in the amount of \$197.76 (\$26.37 X 125% = \$32.96 X 6 units).

CPT code 99212-25 dates of service 11-14-03 and 11-17-03 denied with denial code "MU" (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). Per Encoder.Pro.Com/Ingenix code 99212-25 is considered by Medicare to be a mutually exclusive procedure. A modifier is allowed in

order to differentiate between the services provided. Separate payment for the services may be considered justifiable if a modifier is used appropriately. The requestor billed with the appropriate modifier. Per Rule 134.202(b) reimbursement is recommended in the amount of \$83.82 (\$33.53 X 125% = \$41.91 X 2 DOS).

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 the 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 10-07-03 through 11-21-03 in this dispute.

This Findings and Decision and Order are hereby issued this 26th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

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NOTICE OF INDEPENDENT REVIEW DECISION

October 30, 2004

Re: IRO Case # M5-04-4112 amended 11/22/04, 1/13/05, 1/21/05

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, Rule 133.308 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
2. Explanation of benefits
3. RME report 11/21/03
4. Evaluation 4/3/04
5. DDE 8/25/03
6. D.C. records
7. Inpatient hospital records 9/22/03 – 10/2/03
8. Operative reports 9/22/03, 10/28/02
9. Clinic note 11/8/02
10. Clinic notes 10/02
11. PT progress notes 10/8/02 – 11/21/02
12. X-ray reports right knee 9/27/03, 10/2/02

History

The patient injured his right knee in ___ when he was facing the interior of his truck and removing some tools, when the truck door closed on his legs. The door hit the posterior knees, and the anterior right knee hit the frame of the door. Initially the patient was treated with physical therapy, and he was then referred for orthopedic treatment. On 10/28/02 he underwent examination under anesthesia, diagnostic arthroscopy, synovectomy and chondroplasty. The patient continued in physical therapy, but he continued to have pain. He eventually underwent a total knee arthroplasty on 9/22/03. The patient remained in the hospital and received physical therapy as an inpatient. He was then discharged and continued with outpatient physical therapy.

Requested Service(s)

Neuromuscular reeducation, therapeutic exercises, therapeutic activities, manual therapy, gait training, office visits outpatient (99212-25) 8-25-03 – 12/17/03

Decision

I disagree with the carrier's decision to deny the first hour of physical therapy services per session 10/7/03 – 11/21/03. (CPT code 97110 for a total of one hour per session.)

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

Rationale

The patient injured his knee in ____ and was treated extensively with physical therapy before having arthroscopic surgery on 10/28/02. Following arthroscopic surgery, he continued to have physical therapy until he was re-evaluated by his orthopedic surgeon. He then received a total knee arthroplasty on 9/22/03. Prior to the total knee replacement surgery there was no need for further physical therapy, considering all the physical therapy that the patient had had prior to 8/15/03. Following total knee arthroplasty, physical therapy would be medically necessary and appropriate for four to eight weeks. The patient was discharged from the hospital on 10/3/03 and began outpatient physical therapy on 10/7/03. he would have completed eight weeks by 11/21/03. The need for physical therapy beyond this time period was not established or documented in the records provided for this review.

Office visits, 99212-25 are not appropriate when patients are being seen for physical therapy services.

From 10/7/03 to 11/21/03 the patient was status post total knee replacement surgery. Eight weeks of physical therapy would be medically necessary and appropriate after such surgery. However, it appears from the records provided for this review that the patient received almost two hours of physical therapy three times per weeks. No more than one hour of physical therapy three times per week would be considered medically necessary without special circumstances, and the records provided did not indicate such circumstances.

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

Daniel Y. Chin, for GP