

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

SOAH DOCKET NO. 453-05-4125.M5

MDR Tracking Number: M5-04-4164-01

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 08-06-04.

Date of service 08-04-03 per Rule 133.308(e)(1) were not timely filed and will not be reviewed by the Medical Review Division.

The IRO reviewed durable medical equipment, manual therapy, neuromuscular re-education, electrical stimulation, therapeutic procedures, supplies, chiropractic manipulation, neuromuscular stimulation, ultrasound, therapeutic activities and office visits rendered 08-11-03 through 12-19-03 that were denied based upon "V".

The IRO determined that services provided on 08-11-03 (E1399) and 08-22-03 (E1399) as well as services provided on 09-02-03, 09-05-03, 09-10-03, 09-12-03, 09-15-03 and 09-16-03 (total combined maximum of 2 units of 97110 per treatment day/session) **were** medically necessary. The IRO determined that the remainder of care rendered **was not** medically necessary. The respondent raised no other reasons for denying the services listed above.

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 09-09-04, 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 99070 dates of service 08-06-03, 08-08-03, 08-11-03, 08-13-03, 08-15-03, 08-18-03, 08-20-03, 08-22-03, 08-25-03, 08-27-03 and 08-29-03 (11 DOS) denied with denial code "G/B377" (bundled procedure, no separate payment allowed). Per Rule 133.304(c) the carrier did not specify what service code 99070 was global to. Reimbursement is recommended per the Medicare Fee Schedule effective 08-01-03 in the amount of \$165.00 (\$15.00 X 11 DOS).

CPT code 98943 dates of service 08-06-03, 08-08-03, 08-11-03, 08-13-03, 08-15-03, 08-18-03, 08-20-03, 08-22-03, 08-25-03, 08-27-03 and 08-29-03 (11 DOS) denied with denial code "N/X322" (documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge). The requestor did not submit documentation for review. No reimbursement is recommended.

HCPCS code E0745 date of service 11-17-03 was denied with denial code "A/X170" (pre-authorization was required, but not requested for service per TWCC Rule 134.600). Per Rule 134.600(h)(11) the carrier did not provide documentation that the services are in excess of \$500.00 per item (either purchase or expected cumulative rental). Reimbursement is recommended in the amount of \$89.51 per the Medicare DMEPOS 2003 Fee schedule.

Review of CPT codes 98943, 97140, 97112, 97032, 97110 and 99070 date of service 12-04-03 revealed that neither party to the dispute provided EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. Per Rule 133.307(e)(3)(B) the respondent as required did not provide EOBs. Therefore these services are not reviewed and 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 08-06-03 through 11-17-03 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 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 – AMENDED DECISION

Date: October 29, 2004

RE:

MDR Tracking #: M5-04-4164-01

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:

- Statement letter from ____
- Consultation notes from ____
- Operative reports from ____
- Treatment notes from ____
- Therapeutic activity notes

Submitted by Respondent:

- Peer reviews
- IME report
- Daily notes
- Objective test findings

Clinical History

According to the supplied documentation it appears that on ____ the claimant sustained an injury when she was involved in a motor vehicle accident while at work. The claimant sustained injuries to her neck, right shoulder, mid-back, right elbow and right wrist. The claimant was then seen on 3/20/03 by _____. The claimant began conservative chiropractic treatment. An EMG was performed on 5/15/03 by ____ and revealed carpal tunnel syndrome on the right (moderately severe) and traumatic radial tunnel syndrome on the right (severe). There was also evidence of a right C6 and C7 radiculopathy. On 6/17/03 ____ performed a right radial tunnel release and a right carpal tunnel release. The claimant underwent post operative rehabilitation under the care of _____. On 10/22/03 the claimant underwent a right interior submuscular ulnar nerve transposition at the elbow with ____ again performing the procedure. Active and passive modalities continued. The documentation ends here.

Requested Service(s)

E1399 – durable medical equipment, 97140 – manual therapy, 97112 – neuromuscular re-education, 97032 – electrical stimulation, 97110 – therapeutic procedures, 99070 – supplies, 98943 – chiropractic manipulation, E0745 – neuromuscular stimulation, 97035 – ultrasound, 97530 – therapeutic activities, office visits rendered between 8/11/03 and 12/19/03.

Decision

I disagree with the insurance carrier and find that the services provided on 8/11/03 (E1399) and 8/22/03 (E1399) was medically necessary. I also disagree with the carrier that the services provided on 9/2/03, 9/5/03, 9/8/03, 9/10/03, 9/12/03, 9/15/03, and 9/16/03 (total combined maximum of 2 units of 97110 per

treatment day/session) were medically necessary. I agree with the insurance carrier that the remainder of care rendered was not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears the claimant sustained an injury on _____. The claimant began care on 3/24/03 with _____ and began an active and passive therapy program. After conservative therapy failed, the claimant was referred for a needle EMG which presented evidence leading toward the surgery which occurred on 6/17/03. Surgery dated 6/17/03 included a right radial tunnel release and right carpal tunnel release. After the claimant was released to rehabilitation, then post surgical therapy would be indicated. According to the Official Disability Guidelines Treatment in Workers' Compensation 2004 edition (page 122), physical therapy is recommended up to 20 visits over a 10 week period. At that time it would be necessary for the claimant to begin an aggressive home based exercise program. The claimant again underwent surgery on 10/22/03 for right anterior submuscular ulnar nerve transposition. According to the Official Disability Guidelines, 6 physical therapy sessions would be indicated. The amount of therapy rendered in this case after the initial 20 sessions post surgical and after the 6 sessions after the 2nd surgery, no other therapy is considered reasonable or necessary. The use of topical creams is also not considered reasonable or necessary and can be purchased at a minimal charge at any local pharmacy. According to the table of disputed services, the initial therapies were limited to a passive basis and then were transitioned into an active based protocol. On the dates of service that include active therapies, maximum amount of therapeutic procedures rendered should be limited to 2 units, and the remainder of therapy to be continued on a home based exercise program utilizing Theraband and exercise putty. No other therapy is considered reasonable or medically necessary for treatment of the compensable injury.