

MDR Tracking Number: M5-04-4235-01

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 08-16-04.

The IRO reviewed office visits and required reports for dates of service 10-30-03 through 06-28-04 that were denied based upon "V".

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.

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 09-10-04, 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 99080-73 date of service 09-29-03 denied with denial code "O" (denial after reconsideration). Per Rule 133.304(c) the carrier did not specify the original reason for denial or submit an original denial. Reimbursement per Rule 133.106(f) in the amount of \$15.00 is recommended.

CPT code 99213 date of service 09-29-03 denied with denial code "O" (denial after reconsideration). Per Rule 133.304(c) the carrier did not specify the original reason for denial or submit an original denial. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$66.19 (\$52.95 X 125%).

CPT code 99080-73 date of service 11-04-03 denied with denial code "F" (fee guideline reduction). Per Rule 133.106(f) reimbursement is recommended in the amount of \$15.00.

CPT code 99080 date of service 11-11-03 denied with denial code "F" (fee guideline reduction). CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate. Relevant information (i.e. redacted EOBs-with same or similar services showing amount billed is fair and reasonable) was not submitted by the requestor. No reimbursement is recommended.

CPT code 99080-73 dates of service 12-03-03, 02-27-04, 03-26-04, 04-29-04, 05-24-04 and 06-28-04 denied with a "V" (unnecessary medical treatment based on a peer review). The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of \$90.00 (\$15.00 X 6 DOS).

CPT code 99213 dates of service 12-17-03 and 01-06-04 denied with denial code "D" (previous recommendation will stand as defined and no additional recommendation is due based on TWCC Medical Fee Guidelines/Rules). Per Rule 133.304(c) the carrier did not specify which service code 99213 was a duplicate to. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$132.38 (\$66.19 X 2 DOS). The MAR for 12-17-03 is \$52.95 X 125% = \$66.19 and the MAR for 01-06-04 is \$68.24 (\$54.59 X 125%) however, the requestor only billed \$66.19.

Review of CPT code 98940 date of service 12-17-03 revealed that neither the requestor nor the respondent submitted a copy of the EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement recommended.

CPT code 99080-73 dates of service 01-06-04 and 01-23-04 denied with denial code "D" (previous recommendation will stand as defined and no additional recommendation is due based on TWCC Medical Fee Guidelines/Rules). Per Rule 133.304(c) the carrier did not specify which service code 99213 was a duplicate to. Reimbursement per the Medical Fee Guideline effective 08-01-03 is recommended in the amount of \$30.00 (\$15.00 X 2 DOS).

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 09-29-03 through 06-28-04 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 21st day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

October 25, 2004

Rosalinda Lopez
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 #: M5-04-4235-01
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 47 year-old female injured her wrists on ___ while doing repetitive work. She has been treated with medications, therapy and epidural injections.

Requested Service(s)

Office visits and required reports for dates of service 06/28/04, 05/24/04, 04/29/04, 04/12/04, 03/26/04, 03/16/04, 02/27/04, 01/23/04,12/03/03, 12/01/04, 11/04/03, and 10/30/03

Decision

It is determined that there is no medical necessity for the office visits and required reports for dates of service 06/28/04, 05/24/04, 04/29/04, 04/12/04, 03/26/04, 03/16/04, 02/27/04, 01/23/04,12/03/03, 12/01/04, 11/04/03, and 10/30/03

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the office visits and required reports for dates of service in question. Frequency, type and duration of services must be reasonable and consistent with the standard of the health care community. Physical therapy and chiropractic treatment guidelines for carpal tunnel syndrome, sprain/strain of elbow and forearm or sprain/strain of the wrist and hand indicate a fading of treatment frequency from up to 3 visits per week to 1 or less plus self-directed home therapy for a total treatment time of up to 8 weeks. Chiropractic services beyond 8 weeks, for an unverifiable soft tissue injury, is not standard of care and can not be validated as cost-effective care. Therefore, it is determined that there is no medical necessity for the office visits and required reports for dates of service 06/28/04, 05/24/04, 04/29/04, 04/12/04, 03/26/04, 03/16/04, 02/27/04, 01/23/04,12/03/03, 12/01/04, 11/04/03, and 10/30/03.

Sincerely,