

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 August 23, 2004. Per Rule 133.307(d)(1) dates of service 08/19/03 through 08/22/03 were not filed within the 365-day timeframe and can not be reviewed.

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 visits, therapeutic procedures, paraffin bath, diathermy, unlisted therapeutic procedures, chiropractic manipulation, and therapeutic procedures-group during the period of 08/29/03 through 09/09/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 September 15, 2004, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 99211-25-52 (2) for dates of service 08/25/03 and 08/26/03 denied as "D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider". Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$23.36 (\$11.68 x 2, amount health care provider is requesting) is recommended.
- CPT Code 97018 (2) for dates of service 08/25/03 and 08/26/03 denied as "D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider". According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$7.55 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$15.08 (\$7.54 x 2, amount health care provider is requesting) is recommended.
- CPT Code 97018 for date of service 08/27/03 denied as "F, M456 – The maximum number of physical therapy services has been exceeded for this date of service". The respondent has not submitted convincing evidence to support their denial. According to the Medicare Fee Schedule plus the 125% allowance,

- the reimbursable amount is \$7.55 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$7.54 (amount health care provider is requesting) is recommended.
- CPT Code 97024 (2) for dates of service 08/25/03 and 08/26/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$5.54 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$11.06 ($\5.53×2, amount health care provider is requesting) is recommended.
 - CPT Code 97024 for date of service 08/27/03 denied as “F, M456 – The maximum number of physical therapy services has been exceeded for this date of service”. The respondent has not submitted convincing evidence to support their denial. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$5.54 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$5.53 (amount health care provider is requesting) is recommended.
 - CPT Code 97139-EU for dates of service 08/25/03 and 08/26/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$18.26 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$36.50 ($\11.25×2, amount health care provider is requesting) is recommended.
 - CPT Code 97139-EU for dates of service 09/11/03 and 09/15/03 denied as “N, F”. Per Rule 133.307(g)(3)(B) the requestor did not submit pertinent medical records to support the services were rendered as billed. Reimbursement is not recommended.
 - CPT Code 97124 for date of service 08/25/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$25.70 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$25.69 (amount health care provider is requesting) is recommended.
 - CPT code 98943 for dates of service 08/25/03 and 08/26/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. Per Rule 134.202(c)(6) reimbursement is recommended and the carrier shall assign a relative value.
 - CPT Code 97110 for date of service 08/26/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. Per Rule 134.202(b) and (c) requestor did not provide relevant information to support services were rendered as billed. 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 is not recommended.

- CPT Code 97150 for date of service 08/26/03 denied as “D, U301 – This item was previously submitted and reviewed with notification of decision issued to payor/provider”. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$21.38 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$21.37 (amount health care provider is requesting) is recommended.
- CPT Code 97012 for date of service 08/27/03 denied as “F, M456 – The maximum number of physical therapy services has been exceeded for this date of service”. The respondent has not submitted convincing evidence to support their denial. According to the Medicare Fee Schedule plus the 125% allowance, the reimbursable amount is \$17.21 per unit. Per Rule 134.202(b) & (c)(1) reimbursement in the amount of \$17.20 (amount health care provider is requesting) is recommended.
- CPT Code 99080 for date of service 09/03/03 denied as “U”. Per Rule 133.106(a) the Commission has jurisdiction over fees for required reports and records. Per Rule 137.307(g)(3)(B) the requestor did not submit pertinent information to support the services were rendered as billed. Reimbursement is not recommended.

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 the fair and reasonable rate as set forth in 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 08/25/03 through 08/27/03, and 09/03/03 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 Decision and Order is hereby issued this 22nd day of October 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO Decision

October 12, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-4331-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear ____

____ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- certificate of medical necessity 09/20/04
- correspondence and articles
- office visits 08/19/03 – 09/23/03
- daily progress notes 08/19/03 – 09/15/03
- therapeutic procedure notes 08/26/03 – 09/09/03

Clinical History:

The records indicate the patient was injured on _____. The patient was working as a food processor for approximately 2 years when she began having left elbow, left forearm, and thumb pain. Over the course of treatment after her injury she received passive therapy with minimal results. In April of 2003 she underwent MRI of the left arm. She also

received injection therapy and additional therapy.

She was evaluated by another doctor on August 19, 2003 who recommended completion of 13 sessions of active/passive physical management treatment. She was reevaluated on 09/23/03, and it was determined that additional physical therapy was not a proper course of treatment. She was referred for an orthopaedic evaluation to determine if she was a surgical candidate. She did eventually have surgical intervention.

Disputed Services:

Office visits, therapeutic procedures, paraffin bath, diathermy, unlisted therapeutic procedures, chiropractic manipulation, special report and therapeutic procedures-group, during the period of 08/29/03 thru 09/09/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:

Since the claimant failed previous conservative treatment, there is no clinical justification for an additional trial of conservative care. In reviewing the denied services, it indicates that most of the denied services had previously been performed. In addition, there is nothing in the records that indicate the patient's condition required one-on-one therapeutic procedures or procedures in a group setting. Instruction in a home exercise program would have been appropriate, and these could have been done without direct in office observation. This further confirms lack of medical necessity of these denied services that were performed, and the fact that no significant clinical benefit was obtained, and the patient required surgical intervention. The mere fact that over 1 year and 7 months had passed since the patient's on the job injury should have lead to the decision to request a surgical consultation prior to any additional services of which most had previously been performed or could have been done in a home setting. In conclusion, all office visits, paraffin bath, diathermy, unlisted therapeutic procedures, chiropractic manipulation, special report, and therapeutic procedures-group during the period of 08/29/03 through 09/09/03 were not medically necessary for the treatment of this patient's on the job injury.

Sincerely,