

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 09-09-04.

The IRO reviewed radiology exam, hot/cold packs, ultrasound, exercises, stimulation, activities, re-education, manipulation, office visits and muscle testing rendered from 09-02-03 through 03-31-04 that were denied based upon "U".

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.

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 01-11-05, 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 97014 date of service 08-22-03 denied with denial code "AG" (Medicare fee schedule reimbursement is not valid for this service). CPT code 97014 was not a valid code for billing Medicare as of 08-01-03. No reimbursement recommended.

CPT code 97010 dates of service 08-22-03, 09-02-03 and 09-03-03 denied with denial code "NC" (a service has been billed for which a payment is not allowed under the fee schedule. Service is either not covered or not recognized). Code 97010 for dates of service on or after 08-01-03 is a bundled service code and considered an integral part of a therapeutic procedure(s). No reimbursement is recommended.

CPT code 97035 dates of service 08-27-03 and 08-28-03 denied with denial code "F/01" (the charge for the procedure exceeds the amount indicated in the fee schedule). The carrier has made no payment. Reimbursement is recommended per the Medicare Fee Schedule effective 08-01-03 in the amount of \$28.42 ($\$11.37 \times 125\% = \$14.21 \times 2 \text{ DOS}$).

CPT code 97010 dates of service 08-27-03, 08-28-03, code 97110 date of service 10-09-03, code 97124 date of service 10-22-03 and 03-26-04, code 99213 date of service 03-26-04, code G0283 date of service 03-31-04 and code 97024 date of service 03-31-04 revealed neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of providers request for EOBs. These services will not be reviewed. No reimbursement recommended.

CPT code 97014 date of service 09-02-03 denied with denial code “NC” (a service has been billed for which a payment is not allowed under the fee schedule. Service is either not covered or not recognized). CPT code 97014 was not a valid code for billing Medicare as of 08-01-03. No reimbursement recommended.

CPT code 97250 date of service 09-03-03 denied with denial code “F/JM” (accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid). The carrier has made no payment. Reimbursement is not recommended as code 97250 is not a valid code for billing Medicare as of 08-01-03.

CPT code 99213 date of service 09-05-03 denied with denial code “F/JM” (accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid). The carrier has made no payment. Per the Medicare Fee Schedule this is a valid code. The MAR per the Medicare Fee Schedule is \$59.00 ($\$47.20 \times 125\%$). The requestor billed \$47.20 therefore this is the recommended reimbursement.

CPT code 97112 date of service 09-10-03 denied with denial code “F” (fee guideline MAR reduction). An EOB from the respondent indicates payment being made. The requestor was contacted and it was verified that no payment has been received. Reimbursement is recommended per the Medicare Fee Schedule effective 08-01-03 in the amount of \$33.41 ($\$26.73 \times 125\%$).

CPT code 97530 (3 units) date of service 09-24-03 denied with denial code “F/01” (the charge for the procedure exceeds the amount indicated in the fee schedule). The carrier has made a payment of \$98.88. Additional reimbursement is not recommended.

CPT code 97124 date of service 10-09-03 denied with denial code “G”(global). Per Rule 13.304(c) the carrier did not specify which service code 97124 was global to. Reimbursement is recommended per the Medicare Fee Schedule in the amount of \$25.70 ($\$20.56 \times 125\%$).

CPT code 98941 dates of service 10-09-03, 10-14-03, 10-15-03 and 10-16-03 denied with denial code “F/JM” (accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid). The carrier has made no payment. Per the Medicare Fee Schedule this is a valid code. Reimbursement is recommended per the Medicare Fee Schedule effective 08-01-03 in the amount of \$167.56 ($\$33.51 \times 125\% = \$41.89 \times 4 \text{ DOS}$).

CPT code 95831 (8 units) date of service 01-29-04 denied with denial code “F/JM” (accurate coding of services rendered is essential for proper reimbursement. The code and/or modifier billed is invalid). Per the Medicare Fee Schedule this is a valid code. The carrier has made a payment of \$33.41. The MAR per the Medicare Fee Schedule is \$220.24 ($\$22.02 \times 125\% = \$27.53 \times 8 \text{ units}$). Additional reimbursement per the Medicare Fee Schedule is recommended in the amount of \$186.83.

CPT code G0283 date of service 03-01-04 denied with denial code “F/01” (the charge for the procedure exceeds the amount indicated in the fee schedule). The carrier has made no payment. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$13.41 ($\$10.73 \times 125\%$).

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 08-27-03 through 03-01-04 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 January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh
Enclosure: IRO Decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758
Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 4, 2005

Re: IRO Case # M5-05-0115 amended 1/10/05, 1/20/05

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, 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
2. Explanation of benefits
3. Report MRI right knee 10/21/03
4. Operative report Dr. Allred 12/5/03
5. Orthopedic consult Dr. Allred 10/30/03
6. Follow up notes Dr. Allred 10/28/03, 1/5/04
7. Medical note Dr. Harmon 3/16/04
8. Subsequent medical narrative Dr. Harmon 1/29/04
9. Initial FCE 3/30/04
10. Daily notes reports 8/22/03 – 3/31/04

History

The patient injured his right knee in ___ while exiting a truck. The patient was started on physical therapy on 8/22/03. He was treated conservatively but continued to have pain. A 10/21/03 MRI of the knee showed a tear of the posterior horn of the medial meniscus and chondromalacia of the medial compartment. The patient was referred for orthopedic consultation on 10/30/03 at which time surgery to repair the meniscus was recommended. The patient underwent surgery on 12/5/03. Physical therapy continued until 3/31/04.

Requested Service(s)

Radiology exam, hot/cold packs, ultrasound, exercises, stimulation, activities, reeducation, manipulation, office visits, muscle testing 9/2/03 –3/31/04

Decision

I agree with the carrier's decision to deny the requested services from 10/22/03 forward.

I disagree with the decision to deny treatment prior to 10/22/03.

Rationale

The patient injured his knee in ___ and began conservative treatment on 8/22/03. An MRI on 10/21/03 showed a prominent tear of the posterior horn of the medial meniscus. Continued physical therapy beyond eight weeks in the absence of improvement is not indicated. The patient was referred for orthopedic consultation on 10/30/03. Surgery was recommended on that visit, and the patient underwent arthroscopic partial medial meniscectomy on 12/5/03.

Following post-surgical rehabilitation, the patient was seen by his orthopedic surgeon for follow up on 1/5/04. On that visit the patient was described as being "essentially asymptomatic" and was released from care. However, the patient continued in chiropractic treatment for another two and one half months. There was no documented need for this

continued treatment. The patient was four weeks post surgery and was “really getting along well,” according to his orthopedic surgeon.

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

Daniel Y. Chin, for GP