

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 09-20-04.

Date of service 09-17-03 was not timely filed per Rule 133.308(e)(1) and will not be reviewed by the Medical Review Division.

The IRO reviewed office visits, manual therapy, stimulation, exercises, ultrasound, gait training, analysis and prolonged service rendered from 12-22-03 through 03-26-04 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 11-18-04, 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 99213 dates of service 12-29-03, 01-05-04, 02-17-04, 02-18-04, 02-20-04, 02-25-04, 03-05-04, 03-09-04, 03-16-04, 03-18-04, 03-19-04, 03-24-04 and 03-26-04 denied with denial code "N/TG, F/YF" (documentation does not support the service billed/reduced or denied in accordance with the appropriate fee guideline group rule and/or maximum allowable reimbursement). The carrier has made no payment. Per Rule 133.307(g)(3)(B) the requestor submitted documentation to support documentation criteria. The MAR per the Medicare Fee Schedule for the 2003 dates of service is \$59.00 (\$47.20 X 125%). The MAR per the Medicare Fee Schedule for the 2004 dates of service is \$61.98 (\$49.58 X 125%), however, the requestor billed \$59.00 for all dates of service in dispute, therefore reimbursement is recommended in the amount of \$767.00 (\$59.00 X 13 DOS).

CPT code 99354 date of service 12-31-03 denied with denial code "N/TG" (documentation does not support the service billed). The carrier has made no payment. Per Rule 133.307(g)(3)(B) the requestor submitted documentation to support documentation criteria. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$140.34 (\$112.27 X 125%).

CPT code 97010 date of service 12-29-03 denied with denial code "G" (unbundling). CPT code 97010 is a bundled service code and considered an integral part of a therapeutic procedure(s). Per Rule 134.202(B) no reimbursement is recommended.

CPT code 95833 dates of service 12-22-03 and 03-16-04 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service code 95833 was global to. These services will be reviewed per the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$46.00 for date of service 12-22-03 ($\$36.80 \times 125\%$) and \$40.91 for date of service 03-16-04 ($\$32.73 \times 125\%$).

CPT code 95851 date of service 12-22-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service code 95851 was global to. This service will be reviewed per the Medicare Fee Schedule. Reimbursement is recommended in the amount of \$30.61 ($\$24.49 \times 125\%$).

CPT code 96004 date of service 12-22-03 denied with denial code "N/TG" (documentation does not support the service billed). The carrier has made no payment. Per Rule 133.307(g)(3)(B) the requestor submitted documentation to support documentation criteria. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$132.56 ($\$106.05 \times 125\%$).

CPT code 99080-73 dates of service 09-22-03 and 02-17-04 denied with denial code "F" (fee guideline MAR reduction). Reimbursement is recommended per Rule 133.106(f)(1) in the amount of \$30.00 ($\$15.00 \times 2 \text{ DOS}$) per Rule 129.5.

CPT code 99080 date of service 10-27-03 denied with denial code "F/MD" (valid modifier is required for service). The proper modifier was not listed for this service when billed. Per Rule 134.202(B) no reimbursement recommended.

CPT code G0283 (2 units) date of service 12-29-03 denied with denial code "S" (supplemental payment). The carrier per the EOB submitted made a payment of \$26.82. The MAR per the Medicare Fee Schedule is \$29.82 ($\$11.93 \times 125\% = \$14.91 \times 2 \text{ units}$). Additional reimbursement is recommended in the amount of \$3.00.

CPT code G0283 (2 units) date of service 01-05-04 denied with denial code "S" (supplemental payment). The carrier per the EOB submitted made a payment of \$26.82. The MAR per the Medicare Fee Schedule is \$26.82 ($\$10.73 \times 125\% = \$13.41 \times 2 \text{ units}$). No additional reimbursement is recommended.

CPT code 97014 dates of service 02-18-04, 02-20-04, 02-25-04 and 03-01-04, denied with denial code "NC" (a service has been billed for which a payment is not allowed under the fee schedule. The service is either not covered or the service is not recognized as a valid service). Per the Medicare Fee Schedule this is not a valid code. No reimbursement recommended.

HCPCS code A4556 dates of service 02-20-04, 02-25-04 and 03-01-04 denied with denial code "G"

(unbundling). Per Rule 133.304(c) the carrier did not specify which service code 95833 was global to. Reimbursement is recommended in the amount of \$36.42 (\$12.14 X 3 DOS) per the DMEPOS 2004 Fee Schedule.

CPT code 96004 date of service 03-16-04 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service code 96004 was global to. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$143.79 (\$115.03 X 125%).

Review of CPT code 95851 date of service 03-16-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of providers request for an EOB. Per Rule 133.307(e)(3)(B) the requestor did not provide an EOB as required. Reimbursement per the Medicare Fee Schedule is recommended in the amount of \$23.15 (\$18.52 X 125%).

Review of CPT code 99080-73 date of service 05-06-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of providers request for an EOB. Per Rule 133.307(e)(3)(B) the requestor did not provide an EOB as required. Reimbursement per Rule 129.5 is recommended in the amount of \$15.00.

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 09-22-03 through 05-06-04 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 20th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh
Enclosure: IRO Decision

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 15, 2004

Re: IRO Case # M5-05-0286 amended 12/31/04, 1/16/05

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 Doctor of Chiropractic who is licensed in Texas, 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. D.C. treatment notes
4. Lumbar ROM exercise and muscle testing reports

History

The patient injured her lower back in ___ when she was pushing a bin full of clothing, and she felt a pop on the right side of her lower back. She sought the care of a D.C in August 2003. The patient has been treated with therapeutic exercises, chiropractic treatment, injections and gait training.

Requested Service(s)

Office visits, manual therapy, stimulation, exercises, ultrasound, gait training, analysis, prolonged service 12/22/03 – 3/26/04

Decision

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

Rationale

The patient had an adequate trial of conservative therapy prior to the dates in dispute without relief of symptoms or improved function. The SOAP notes provided for this review were lengthy, but lacked subjective and quantifiable findings, such as palpatory findings, DTRs and ROMs. The diagnosis of lumbar sprain/strain is not supported by the records provided for review. The diagnosis appears to be based on a subjective complaint of pain radiating into the lower extremity. There is no clinical evidence of any disk disorder.

Subjective complaints did not improve with the D.C.'s treatment. On 3/9/04, about three months after her initial treatment, the patient's VAS for pain was 8/10, and she had pain radiating into both buttocks and the left lower extremity. The patient also stated that she felt much worse and was bent over and could hardly walk. The D.C.'s treatment had failed to be beneficial to the patient.

The D.C.'s treatment was over utilized and inappropriate. The documentation provided for this review does not support the treatment in dispute.

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

Daniel Y. Chin, for GP