

MDR Tracking Number: M5-05-0289-01

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 09-20-04.

The IRO reviewed paraffin bath rendered from 12-01-03 through 02-02-04 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 11-17-04, 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 98940 (11 DOS) dates of service 12-01-03, 12-03-03, 12-05-03, 01-16-04, 01-19-04, 01-21-04, 01-23-04, 01-28-04, 01-29-04, 01-30-04 and 02-02-04 denied with denial code "G2" (unbundling-included in global). Per Rules 134.202(a)(4) and 133.304(c) the carrier did not specify which code 98940 was global to. Reimbursement per Rule 134.202(c)(1) for the 2003 services is \$30.14 (\$24.11 X 125%) and for the 2004 services is \$31.35 (\$25.08 X 125%). The requestor billed \$30.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$330.00 (\$30.00 X 11 DOS)**.

CPT code G0283 (5 DOS) dates of service 12-01-03, 12-03-03, 12-05-03, 01-16-04 and 01-19-04 denied with denial code "G2" (unbundling-included in global). Per Rules 134.202(a)(4) and 133.304(c) the carrier did not specify which code G0283 was global to. Reimbursement per Rule 134.202(c)(1) for the 2003 services is \$14.91 (\$11.93 X 125%) and for the 2004 services is \$13.41 (\$10.73 X 125%). The requestor billed \$13.41 for each date of service in dispute. Reimbursement is recommended in the amount of **\$67.05 (\$13.41 X 5 DOS)**.

CPT code 97035 (5 DOS) dates of service 12-01-03, 12-03-03, 12-05-03, 01-16-04 and 01-19-04 denied with denial code "G2" (unbundling-included in global). Per Rules 134.202(a)(4) and

133.304(c) the carrier did not specify which code 97035 was global to. Reimbursement per Rule 134.202(c)(1) for the 2003 services is recommended in the amount of **\$42.63 (\$11.37 X 125% = \$14.21 X 3 DOS)** and for the 2004 services is **\$29.62 (\$11.85 X 125% = \$14.81 X 2 DOS)**.

CPT code 99080-73 dates of service 12-01-03, 12-03-03 and 01-19-04 denied with denial code "U" (unnecessary treatment without peer review). The TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. Reimbursement is recommended in the amount of **\$45.00 (\$15.00 X 3 DOS)**. A Compliance and Practices referral will be made due to the carrier violating Rule 129.5.

CPT code 97530 date of service 01-30-04 denied with denial code "G2" (unbundling-included in global). Per Rules 134.202(a)(4) and 133.304(c) the carrier did not specify which code 97530 was global to. Reimbursement per Rule 134.202(c)(1) is \$34.65 (\$27.72 X 125%). The requestor billed \$33.96 therefore the recommended reimbursement is **\$33.96**.

CPT code 99080-73 date of service 04-30-04 denied with denial code "N17" (not appropriate documented. Upon review documentation submitted did not contain information specific to this service). Documentation submitted by the requestor supports services billed. Reimbursement is recommended in the amount of **\$15.00**.

CPT code 98940 dates of service 05-05-04 and 05-07-04 denied with denial code "N72/N75" (not appropriate documented. Documentation as submitted does not support the therapy modalities/procedures as billed. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan). The requestor submitted documentation that supports the services billed. Reimbursement per Rule 134.202(c)(1) is \$31.35 (\$25.08 X 125%). The requestor billed \$30.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$60.00 (\$30.00 X 2 DOS)**.

CPT code 97530 (4 units) dates of service 05-05-04 and 05-07-04 denied with denial code "N72/N75" (not appropriate documented. Documentation as submitted does not support the therapy modalities/procedures as billed. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan). The requestor submitted documentation that supports the services billed. Reimbursement per Rule 134.202(c)(1) is \$34.65 (\$27.72 X 125%). The requestor listed \$67.92 as being in dispute for each date of service, therefore **\$135.84 (\$67.92 X 2 DOS)** is recommended for reimbursement.

CPT code 97018 dates of service 05-05-04 and 05-07-04 denied with denial code "N72/N75" (not appropriate documented. Documentation as submitted does not support the therapy modalities/procedures as billed. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan). The requestor submitted documentation that supports the services billed. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$15.62 (\$6.25 X 125% = \$7.81 X 2 DOS)**.

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 12-01-03 through 05-07-04 in this dispute.

This Findings and Decision and Order are hereby issued this 9th day of March 2005.

Debra L. Hewitt
Medical Dispute Resolution
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

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NOTICE OF INDEPENDENT REVIEW DECISION

November 9, 2004

Re: IRO Case # M5-05-0289 amended 2/1/05, 3/2/05

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. TWCC 69 forms
4. designated doctor report 5/11/04
5. D.C. dispute position statement 9/13/04
6. D.C. report 10/5/03
7. Employer's first report of injury ____
8. D.C. initial narrative report 11/25/03
9. Report 2/1/03
10. Certification of health care provided 12/22/03
11. M.D. reports
12. FCE 1/30/04
13. Prescription 4/21/04
14. Electrodiagnostic report 5/6/04
15. D.C. treatment notes

History

The patient injured her left wrist in ____ when she fell on the wrist while attempting to restrain an individual at a correctional institution. She presented for chiropractic treatment on 11/25/03. She has been treated with modalities, injections and chiropractic treatment.

Requested Service(s)

Paraffin bath 12/1/03 – 2/2/04

Decision

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

Rationale

The patient received a fair trial of conservative treatment for a diagnosed sprain/strain of the wrist. Although, the use of manipulation was reasonable and medically necessary, the other disputed services.

Including paraffin bath, were inappropriate, over utilized, and not supported by the documentation provided for this review.

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

Daniel Y. Chin, for GP