

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 05-06-04.

The IRO reviewed office visits (99204/99213) rendered from 01-26-04 through 02-11-04 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 12-09-04, 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 97750-FC (16 units) date of service 01-27-04 denied with denial code "F/529" (charge is in excess of unit value or reasonable allowance/fee guideline MAR reduction). The carrier made a payment of \$512.48. The MAR per Rule 134.202(c)(1) is \$548.80 ($\$27.44 \times 125\% = \34.30×16 units). The carrier billed \$534.56. Additional reimbursement is recommended in the amount of **\$22.08 (\$534.56 billed minus carrier payment of \$512.48)**.

Review of CPT code 97035 (2 units) dates of service 01-28-04 and 02-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. The MAR per Rule 134.202(c)(1) is \$14.81 ($\$11.85 \times 125\%$). The requestor billed \$14.21 for each date of service in dispute. Reimbursement is recommended in the amount of **\$28.42 (\$14.21 X 2 units)**. A referral will be made to Compliance and Practices due to the carrier violating Rule 133.307(e)(3)(B) and not providing EOBs as required.

Review of CPT code 99213 dates of service 01-28-04 and 02-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. The MAR per Rule 134.202(c)(1) is \$61.98 ($\$49.58 \times 125\%$). The requestor billed \$59.00 for each date of service in dispute. Reimbursement is recommended in the amount of **\$118.00 (\$59.00 X 2 dates of service)**. A referral will be made to Compliance and Practices due to the carrier violating Rule 133.307(e)(3)(B) and not providing EOBs as required.

Review of CPT code 97032 dates of service 01-28-04 and 02-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. The MAR per Rule 134.202(c)(1) is \$18.73 ($\$14.98 \times 125\%$). The requestor billed \$18.83. Reimbursement is recommended in the amount of **\$18.73**.

A referral will be made to Compliance and Practices due to the carrier violating Rule 133.307(e)(3)(B) and not providing EOBs as required.

CPT code 97035 (3 units) dates of service 01-29-04, 02-02-04 and 02-05-04 denied with denial code "F/615" (time parameters or procedural limits are exceeded/fee guideline MAR reduction). The carrier has made no payment. Review of information submitted by the requestor supported the services billed. The MAR per Rule 134.202(c)(1) is \$14.81 ($\$11.85 \times 125\%$). The requestor billed \$14.21 for each date of service in dispute. Reimbursement is recommended in the amount of **\$42.63 (\$14.21 X 3 units)**.

CPT code 97032 (3 units) dates of service 01-29-04, 02-02-04 and 02-05-04 denied with denial code "F/615" (time parameters or procedural limits are exceeded/fee guideline MAR reduction). The carrier has made no payment. Review of information submitted by the requestor supported the services billed. The MAR per Rule 134.202(c)(1) is \$18.73 (\$14.98 X 125%). The carrier billed \$18.83 for each date of service in dispute. Reimbursement is recommended in the amount of **\$56.19 (\$18.73 X 3 units)**.

CPT code 97113 (24 units) dates of service 02-09-04, 02-11-04, 03-01-04 and 03-04-04 denied with denial code "F/615" (time parameters or procedural limits are exceeded/fee guideline MAR reduction). The carrier has made a payment of \$466.92. Review of information submitted by the requestor supported the services billed. The MAR per Rule 134.202(c)(1) is \$933.84 (\$31.13 X 125% = \$38.91 X 24 units). The requestor billed \$831.12. Additional reimbursement is recommended in the amount of **\$364.20 (\$831.12 billed minus carrier payment of \$466.92)**.

CPT code 97124 (8 units) dates of service 02-09-04, 02-11-04, 03-01-04 and 03-04-04 denied with denial code "F/615" (time parameters or procedural limits are exceeded/fee guideline MAR reduction). The carrier has not made a payment. Review of information submitted by the requestor supported the services billed. The MAR per Rule 134.202(c)(1) is \$210.24 (\$21.02 X 125% = \$26.28 X 8 units). The requestor billed \$205.60 (\$25.70 X 8 units). Reimbursement is recommended in the amount of **\$205.60 (\$25.70 X 8 units)**.

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 01-27-04 through 03-04-04 in this dispute.

This Findings and Decision and Order are hereby issued this 2nd day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

January 21, 2005

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 #: M5-05-0910-01
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 Medicine. 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 49 year-old female injured her low back on ____ when she caught her heel on a pipe causing her to fall. She states she has developed numbness and weakness in her left arm. She complains of pain in her low back when lifting, bending, sitting, standing, and climbing. She has been treated with therapy.

Requested Service(s)

Office visits for dates of service 01/26/04 through 02/11/04

Decision

It is determined that there is no medical necessity for the office visits for dates of service 01/26/04 through 02/11/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates an injury to the patient's lower back occurred, and that an initial evaluation was performed. However, the office visits performed were an "expanded problem-focused" evaluation and a moderately complex type of examination. Medical record documentation does not indicate the necessity of taking this detailed history or performing a detailed examination of this injured worker on each and every visit. Therefore, the office visits for dates of service 01/26/04 through 02/11/04 were not medically necessary to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-0910-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests

Information Submitted by Respondent: