

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 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-20-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The office visits, manual therapy technique, therapeutic exercise, neuromuscular reeducation and special reports for 1-12-04 through 3-3-04, the hot/cold pack therapy and miscellaneous supplies/material for 1-12-04 **were found** to be medically necessary. The office visits, manual therapy technique, therapeutic exercise, neuromuscular reeducation and special reports for 3-4-04 through 8-2-04, the hot/cold pack therapy and miscellaneous supplies/material for 1-13-04 through 8-2-04, functional capacity evaluations, prolonged evaluation and management services before and after direct (face to face) patient care, first hour, telephone call by a physician to a patient or for consultation or coordination of medical management with other healthcare professionals-intermediate, ultrasound-extremity, nonvascular B-scan and/or real time with image documentation for 1-12-04 through 8-2-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services. The amount due the requestor for the medical necessity issues is \$758.83.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute 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 1-19-05, the Medical Review Division submitted a Notice to the 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.

Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge.

Regarding CPT code 72020 on 1-12-04: The carrier reimbursed \$29.29 for one unit. Two units were denied as "D" – reimbursement for unilateral or bilateral procedures is being withheld as the maximum number of occurrences for a single date of service or maximum lifetime for the claim has been exceeded." Neither Trailblaxer Online Fee Schedule or Ingenix Encoder Pro lists a "maximum number of occurrences". **Recommend additional reimbursement of \$58.92 (\$29.46 MAR X 2 DOS).**

Regarding CPT code 99080 for 1-16-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). In accordance with Rule 129.5(d)(2) the doctor shall file the Work Status Report when the employee experiences a change in work status or a substantial change in activity restrictions. There was no change in condition which necessitated this Work Status Report. **Recommend no reimbursement.**

CPT code 99358 on 1-17-04 was denied with an "N" – only care beyond the usual service qualifies for separate reimbursement. Requestor did not submit relevant documentation to support level of service per 133.307(g)(3)(B). **Recommend no reimbursement.**

The carrier denied CPT Code 99080-73 on 1-19-04 and 2-05-04 with an "F" – reimbursement is limited to one report every two weeks. In accordance with Rule 129.5(d)(2) the doctor shall file the Work Status Report when the employee experiences a change in work status or a substantial change in activity restrictions. Requestor submitted relevant information to support delivery of service. The Work Status Report for 1-19-04 was not justified. There was a change in the date to return to work therefore the report for 2-05-04 was justified.

Recommend reimbursement of \$13.50.

Regarding CPT code 97110 for 1-28-04: The requestor billed for four units. The carrier sent an EOB for one unit and reimbursed for one unit. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, 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. **Additional reimbursement not recommended.**

Regarding CPT code 97110 for 2-18-04, 3-3-04, 3-8-04, 4-5-04, 4-12-04 and 4-21-04: the carrier denied these services as "N" – your reconsideration request is incomplete or no EOB was provided (4-21-04). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, 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. **Additional reimbursement not recommended.**

CPT code 99213 on 2-18-04, 3-3-04, 3-8-04, 4-5-04, 4-12-04 was denied as "N" – your reconsideration request is incomplete. Ingenix Encoder Pro describes the criteria for this code as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity." Requestor did not submit relevant, legible documentation to support service rendered per 133.307(g)(3)(B). **Recommend no reimbursement.**

Neither the carrier nor the requestor provided EOB's for CPT code 99358 on 4-6-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$75.60.**

HCPCS Code E1399 on 4-12-04 was denied as "N" – your reconsideration request is incomplete. Requestor did not submit relevant, legible documentation to support service rendered per 133.307(g)(3)(B). **Recommend no reimbursement.**

CPT code 97140 (2 units) on 2-18-04, 3-3-04 (2 units), 3-8-04 (2 units), 4-5-04 (2 units), 4-12-04 (2 units) and 6-2-04 was denied as "N" – your reconsideration request is incomplete. Ingenix Encoder Pro describes the criteria for this code as, "The clinician performs manual therapy techniques including soft tissue and joint mobilization, manipulation, manual traction, and/or manual lymphatic drainage to one or more areas. This code requires direct contact with the patient." Requestor did not submit relevant, legible documentation to support service rendered per 133.307(g)(3)(B). **Recommend no reimbursement.**

CPT code 97112 on 2-18-04, 3-3-04, 3-8-04, 4-5-04 and 4-12-04 was denied as "N" – your reconsideration request is incomplete. Ingenix Encoder Pro describes the criteria for this code as, "The clinician and/or patient perform activities to one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception. This code requires direct contact" Requestor did not submit relevant, legible documentation to support service rendered per 133.307(g)(3)(B). **Recommend no reimbursement.**

5 units of CPT code 97750 on 2-24-04 were billed. Per rule 134.202 (e) (4) FCE's shall be reimbursed in accordance with subsection (c)1) which states reimbursement is "the effective conversion factor adopted by CMS multiplied by 125%." According to Trailblazer Online Fee Schedule the MAR is \$35.66. Five units would be \$178.30. The carrier has paid \$432.09. **No additional reimbursement is recommended.**

Neither the carrier nor the requestor provided EOB's for CPT code 99080 on 4-20-04 and 6-30-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement per Rule 133.306(f) of \$99.10 (\$50.00 + \$49.10).**

Neither the carrier nor the requestor provided EOB's for CPT code 97140 (2 units) on 4-21-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$59.22. (\$29.61 x 2 DOS).**

Regarding CPT code 97750 (2 units) for 6-25-04. The carrier has reimbursed \$71.32 which is the MAR according to Rule 134-202 (b). **Recommend no additional reimbursement.**

The carrier denied CPT Code 99080-73 on 6-21-04 as "V", however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of \$13.50.**

Neither the carrier nor the requestor provided EOB's for CPT code 99214 on 6-21-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of \$101.74.**

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 totaling \$421.58 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after 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 Order is applicable to dates of service 1-12-04 through 6-30-04 as outlined above in this dispute. The amount due the requestor for the medical necessity and fee issues is \$1,180.41.

This Decision and Order is hereby issued this 30th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

February 17, 2005

Amended Letter 03/24/05

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 #: M5-05-1191-01
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 34 year-old male injured his left elbow on ___ while lifting a bag at work and struck his left elbow on a metal tray. Clinical impression shows 1) a left elbow contusion with bursitis over the olecranon with underlying spur and 2) Olecranon bursitis resolving. No fracture appreciated. He did not break the skin. He has been treated with medications and therapy.

Requested Service(s)

Hot/cold pack therapy, miscellaneous supplies/materials, prolonged evaluation and management service before and/or after direct patient care, first hour. Office visits – levels I, II, III, and V, manual therapy technique, therapeutic exercise, neuromuscular reeducation, functional capacity evaluation, special reports, telephone call by a physician to a patient or for consultation or coordination of medical management with other healthcare professionals – intermediate and extremity ultrasound – nonvascular B-scan and/or real time with image documentation for dates of service 01/12/04 through 08/02/04.

Decision

It is determined that there is medical necessity for the office visits – levels I, II, III, and V, manual therapy technique, therapeutic exercise, neuromuscular reeducation and special reports for dates of service 01/12/04 through 03/3/04. There is no medical necessity for these services for dates of service 03/04/04 through 08/02/04.

It is determined that there is medical necessity for the hot/cold pack therapy and miscellaneous supplies/materials for date of service 01/12/04. There is no medically necessary for these services for dates of service 01/13/04 through 08/02/04.

It is determined that there is no medical necessity for the functional capacity evaluation, the prolonged evaluation and management service before and/or after direct patient care - first hour, telephone call by a physician to a patient or for consultation or coordination of medical management with other healthcare professionals - intermediate, and ultrasound, extremity, nonvascular B-scan and/or real time with image documentation for dates of service 01/12/04 through 08/02/04 to treat this patient's medical condition.

Rationale/Basis for Decision

It is clear that the patient sustained a soft tissue injury during the course of normal employment. Standards of care indicate a controlled trial of physical and chiropractic therapy is medically necessary with an expectation of improvement in a patient's condition and a return to the workforce. Continued treatment is expected to improve the patient's condition and initiate restoration of function. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. However, despite this fact, the patient remained off work and treatment continued.

Therefore, the office visits – levels I, II, III, and V, manual therapy technique, therapeutic exercise, neuromuscular reeducation and special reports for dates of service 01/12/04 through 03/03/04 were medically necessary to treat this patient's medical condition as well as the hot/cold pack therapy and miscellaneous supplies/materials for date of service 01/12/04. There is no medically necessary for any service listed above except for the dates of service listed as medically necessary dates.

Additionally, there is no medical necessity for the functional capacity evaluation, prolonged evaluation and management service before and/or after direct patient care - first hour, telephone call by a physician to a patient or for consultation or coordination of medical management with other healthcare professionals - intermediate, and ultrasound, extremity, nonvascular B-scan and/or real time with image documentation for dates of service 01/12/04 through 08/02/04 to treat this patient's medical condition.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive, slightly slanted script.

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

GBS:vn

Attachment

Patient Name:

TWCC ID #: M5-05-1191-01

Information Submitted by Requestor:

- Progress Notes
- Peer Review
- Maximum Medical Impairment
- Diagnostic Tests
- Disputes
- Consults
- Daily treatment Reports
- Durable Medical Equipment

Information Submitted by Respondent:

- Progress Notes
- Medical Analysis
- Consults
- Diagnostic Tests
- Maximum Medical Impairment