

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 12-16-04.

The IRO reviewed paraffin bath, miscellaneous supplies/materials, chiropractic manipulations, office visits, massage, therapeutic exercises, group therapy, and electrical stimulation.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

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

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 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.

Rule 134.202 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additional or exceptions in this section." Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service. Rule 134.202 (e)(9) lists the valid Commission modifiers.

The requestor billed code 97139-EU for dates of service 4-2-04, 4-5-04, 4-6-04, and 4-7-04 and code 97750-MT for dates of service 4-8-04 and 4-29-04. These modifiers are invalid after 8-1-03; therefore, no review and no reimbursement recommended.

Code 99070 was billed for date of service 3-26-04 and denied as "F, JM – accurate coding is essential for proper reimbursement; the code and/or modifier billed is invalid..." This code was billed for a cock-up wrist brace (\$75.00), Bao Zhen Gao analgesic patches, DME #34 (\$8.00), and biofreeze, DME #8 (\$8.00). Per Ingenix EncoderPro, code 99070 is a bundled code and not paid separately. Per Ingenix EncoderPro, wrist braces are assigned with "L" codes; therefore, respondent appropriately denied and no reimbursement recommended.

Code 99080-73 billed for date of service 4-2-04 was denied as "N, 27 – provider charged for a report which was not submitted with the billing. Requestor provided proof of delivery to the respondent; therefore, per Rule 129.5, recommend reimbursement of \$15.00.

Code 99080-73 billed for date of service 4-22-04 was denied as "F, 86 – provider billed for work status report on a subsequent date of service. Per Rule 133.304 (c), the respondent did not state the subsequent date of service and the requestor did not submit a bill to show a subsequent billing for the TWCC-73; therefore, per Rule 129.5, recommend reimbursement of \$15.00.

Code 98943 billed for date of service 12-31-03 was denied as "G, 05 – included in the value of another procedure performed on this date." Per Rule 133.304 (c), the respondent did not state what this code was included with. Per Ingenix EncoderPro, code 98943 is a noncovered service; therefore, no reimbursement recommended.

ORDER

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 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) and (e)(8); 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 12-31-03 through 5-4-04 as outlined above.

This Order is hereby issued this 29th day of March 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

March 10, 2005

Amended Letter 03/18/05

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 #: M5-05-1228-01
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 19 year-old female injured her right hand and fingers on ___ when the shampoo machine she was operating malfunctioned. She has been treated with active and passive therapies.

Requested Service(s)

Paraffin bath, miscellaneous supplies/materials, simultaneous electrical stimulation and ultrasound, chiropractic manipulative treatment, extraspinal, one or more regions, office visits level I, II, and III, massage therapy, muscle testing, therapeutic exercise, group therapy for dates of service 12/31/03 through 05/04/04

Decision

It is determined that there is medical necessity for the paraffin bath, miscellaneous supplies/materials, simultaneous electrical stimulation and ultrasound, chiropractic manipulative treatment, extraspinal, one or more regions, office visits level I, II, and III, massage therapy, muscle testing, therapeutic exercise, and group therapy for dates of service 12/31/03 through 05/04/04 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was treated conservatively and appropriately during the time period in question. She progressed to the point of returning to work and was scheduled for a follow up appointment in two months. However, she did experience an exacerbation of her condition and returned early for treatment. Due to this exacerbation, additional diagnostic testing and treatment was necessary. All services rendered during the time period in question are within the national treatment guidelines for injuries of this nature. Therefore, the paraffin bath, miscellaneous supplies/materials, simultaneous electrical stimulation and ultrasound, chiropractic manipulative treatment, extraspinal, one or more regions, office visits level I, II, and III, massage therapy, muscle testing, therapeutic exercise, and group therapy for dates of service 12/31/03 through 05/04/04 were 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 #: M5-05-1228-01

Information Submitted by Requestor:

- Progress Notes
- Treatment Plan
- Diagnostic Tests

Information Submitted by Respondent: