

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-27-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity.

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

Manual therapy technique and therapeutic activities from 2-16-04 through 4-15-04 were found to be medically necessary. The neuromuscular re-education, ultrasound and electrical stimulation from 2-16-04 through 4-15-04 **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 \$555.90.

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 2-15-04, 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.

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.

CPT code 99214 on 2-16-04 was denied as "YC" – reimbursed per negotiated contract with First Health or one of their other sub-network affiliates". The requestor, in a letter dated 4-4-05 has stated that they have no contract with First Health. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment. **Recommend reimbursement of \$81.00.**

CPT code 97530 on 2-16-04 (3 units) and 2-17-04 (3 units) was denied as "YC" – reimbursed per negotiated contract with First Health or one of their other sub-network affiliates". The requestor, in a letter dated 4-4-05 has stated that they have no contract with First Health. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment. **Recommend reimbursement of \$207.90.**

CPT code G0283 on 2-16-04 and 2-17-04 was denied as "01" – The charge for the procedure exceeds the amount indicated in the fee schedule. **Recommend reimbursement per the Medicare Fee Guidelines of \$26.82 (\$13.41 X 2 DOS).**

CPT code 97530 (3 units) on 3-22-04 was denied as "YC" – reimbursed per negotiated contract with First Health or one of their other sub-network affiliates". The requestor, in a letter dated 4-4-05 has stated that they have no contract with First Health. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment. **Recommend reimbursement of \$103.95.**

Regarding CPT code 99214 on 4-2-04 and 4-15-04 which was denied as "TG" – documentation doesn't support the service billed: Ingenix Encoder Pro lists the criteria for this service 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: a detailed history; a detailed examination; medical decision making of moderate complexity. Requestor did submit relevant documentation to support this level of service. **Recommend reimbursement of \$190.00 (\$95.00 X 2 DOS).**

The carrier denied CPT code 99080-73 on 4-2-04 and 4-15-04 as "TD" – the TWCC 73 was not properly completed or was submitted in excess of the filing requirements." Per Rule 129.5(d) the doctor shall file the Work Status Report:

(2) when the employee experiences a change in work status or a substantial change in activity restrictions;
Recommend reimbursement of \$30.00 (\$15.00 X 2 DOS).

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 from 2-16-04 through 4-15-04 totaling \$1,195.57 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 Findings and Decision is hereby issued this 4th day of April 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

March 30, 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 #: M5-05-1288-01
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 63 year-old female injured her shoulder on _____. She has been treated with therapy and surgery.

Requested Service(s)

Neuromuscular re-education, ultrasound, manual therapy technique, therapeutic activities, electrical stimulation for dates of service 02/16/04 through 04/15/04

Decision

It is determined that there is medical necessity for the manual therapy technique and therapeutic activities to treat this patient's medical condition for dates of service 02/16/04 through 04/15/04. However, the neuromuscular re-education, ultrasound, and electrical stimulation are not medically necessary to treat this patient's medical condition for dates of service 02/16/04 through 04/15/04.

Rationale/Basis for Decision

According to the *Guidelines for Chiropractic Quality Assurance and Practice Parameters* an 8-week period of supervised post-operative therapeutic exercises is medically indicated for a patient that undergoes surgical repair of the shoulder. Additionally, an 8-week trial period of manual therapy techniques due to the range of motion limitations is an acceptable treatment plan and is adequately documented within the medical records. However, medical record documentation does not indicate the need for passive therapies such as ultrasound and unattended electrical stimulation nor does it indicate the diagnosis or physical examination findings that demonstrated the type of neuropathology that would necessitate the application of the neuromuscular reeducation service. Therefore, the manual therapy technique and therapeutic activities are medically necessary to treat this patient's medical condition for dates of service 02/16/04 through 04/15/04. However, the neuromuscular re-education, ultrasound, and electrical stimulation are not medically necessary to treat this patient's medical condition for dates of service 02/16/04 through 04/15/04.

Sincerely,



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

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1288-01

Information Submitted by Requestor:

- Office Notes
- Claims

Information Submitted by Respondent: