

MDR Tracking Number: M5-05-1810-01

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 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 2-28-05.

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.

The chiropractic manipulation, office visits, lumbar brace, somatosensory testing, manual therapy-distinct procedural service, mechanical traction therapy, electrical stimulation-other than wound, neuromuscular re-education, therapeutic exercises and CPT code 97039-CM (Continuous Passive Motion) from 3-2-04 through 8-16-04 were 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 \$2,940.35.**

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 3-21-05 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.

CPT code 98940 on 3-2-04 was denied by the carrier as "G - this procedure is mutually exclusive to another procedure on the same date of service." The requestor did not append the -25 modifier as required when it is a separately identifiable E/M service per Ingenix Encoder Pro. **Recommend no reimbursement.**

CPT code 99070 (Baldroom and Inflammation) were denied by the carrier as "U - unnecessary medical treatment." The CPT Expert Appendices state that this supply is

bundled into the Evaluation and Management Code. The correct HCPCS code was not used. **Recommend no reimbursement.**

CPT code 97140-59 on 3-4-04, 3-5-04 and 3-8-04 and 4-14-04 was denied as “N – Documentation to support his charge was insufficient.” – Per Ingenix Encoder Pro, “a 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 documentation to support level of service per Rule 133.307(g)(3)(B). **Recommend no reimbursement.**

Regarding CPT code 95934 (8 units) on 3-30-04: In a certified letter to the carrier dated 12-14-04 the requestor states that she is resubmitting this date of service because the original submission contained the incorrect CPT code. Recommend no reimbursement.

Regarding CPT code 95904 (8 units) on 3-30-04: The carrier states that they have reimbursed for 6 units and that they will reimburse the additional 2 units. Recommend reimbursement of \$109.72.

Regarding CPT code 97012 on 5-5-04: Neither the carrier nor the requestor provided EOB's. The requestor submitted convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). Recommend reimbursement of \$17.21.

The carrier denied CPT Code 99080-73 on 6-11-04 with a V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. A referral will be made to Compliance and Practices for this violation. 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 \$15.00.

This Findings and Decision is hereby issued this 19th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

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 \$3,082.28 from 3-3-04 through 8-16-04 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 hereby issued this 19th day of May 2005.

Manager, Medical Necessity Team
Medical Dispute Resolution
Medical Review Division

Enclosure: IRO decision

May 11, 2005

May 3, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT

Add CPT code and change the period of service under "Disputed Services"

Re: Medical Dispute Resolution
MDR #: M5-05-1810-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic, and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-1810-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

Correspondence

Physical therapy notes 03/01/04 – 08/16/04

FCE 05/03/04 – 06/10/04

Nerve conduction study 11/18/01 – 03/30/04

Radiology reports 03/12/04 – 03/30/04

Information provided by Respondent:

Designated doctor reviews

Clinical History:

The records indicate the patient was injured on the job on ____, after which he immediately experienced pain. The records indicate the patient was injured on the job on ____ stating he was injured while cutting a tree. He fell off of a ladder about 14 feet. He immediately experienced pain.

He presented for evaluation. A thorough evaluation was performed, which revealed significant subjective/objective findings to warrant a treatment program. Over the course of time, additional diagnostic testing in the form of MRI and electrodiagnostic study testing was performed, which confirmed the patient's injuries. The records indicate the patient received initially passive therapy with progression to active therapy, once tolerable.

Disputed Services:

Chiropractic manipulation, office/outpatient visits-established, lumbar brace, somatosensory testing, manual therapy-distinct procedural service, mechanical traction therapy, electrical stimulation-other than wound, neuromuscular re-education, therapeutic exercises and **CPT code 97039** during the period of 03/02/04 through **08/16/04**.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment, services and testing in dispute as stated above was medically necessary in this case.

Rationale:

There is sufficient documentation on each date of service to clinically justify and warrant the treatment this patient received. National treatment guidelines allow for this type of treatment for this type of injury. In conclusion, there is sufficient documentation to clinically justify each denied service and, therefore, the denied services listed above were, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's on-the-job injury.