

MDR Tracking #M5-05-2058-01

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, 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 03-23-05.

The IRO reviewed established patient office visits, levels II, III and IV (99212, 99213 and 99214), manual therapy technique (97140), ultrasound (97035), unattended electrical stimulation (G0283), paraffin baths (97018), therapeutic exercises, group (97150), therapeutic exercises (97110) and chiropractic manipulative therapy spinal 1-2 areas (98940) rendered from 03-26-04 through 06-16-04 that were denied based upon "V".

The IRO determined that the electrical stimulation (G0283), manual therapy techniques (97140) and ultrasound treatments (97035) from 03-26-04 through 05-03-04 only and the office visit level III (99213) on 04-19-04 as well as the chiropractic manipulative therapy, spinal 1-2 areas (98940) on 04-29-04 **were** medically necessary. The IRO determined that all remaining services and procedures **were not** medically necessary. The amount of reimbursement due from the carrier for the medical necessity issues equals **\$843.06**.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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

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 04-25-05, 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 99205 date of service 03-30-04 denied with denial code "G/U454" (global/included in the value of the surgery or anesthesia procedure). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99205 was global to. Per Ingenix Encoder.Pro no coding conflicts were found for the services billed on 03-30-04. Reimbursement is recommended in the amount of **\$205.39 (\$154.31 X 125%)**.

CPT code 99213 dates of service 04-20-04 and 05-04-04 denied with denial code "G/U454" (global/included in the value of the surgery or anesthesia procedure). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code 99213 was global to. Per Ingenix Encoder.Pro no coding conflicts were found for the services billed on 04-20-04 and 05-04-04. Reimbursement is recommended in the amount of **\$123.96 (\$49.58 X 125% = \$61.98 X 2 DOS).**

CPT code J2001 (2 units) date of service 04-20-04 denied with denial code "G/B377" (this is a bundled procedure. No separate payment allowed). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code J2001 was global to. Reimbursement is recommended in the amount of **\$2.20 (\$.88 X 125% + \$1.10 X 2 units).**

HCPCS code A4209 date of service 04-20-04 denied with denial code "G/B377" (this is a bundled procedure. No separate payment allowed). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code A4209 was global to. HCPCS code A 4209 is not found on the 2004 DMEPOS Fee Schedule. No reimbursement is recommended.

CPT code 99080-73 date of service 04-23-04 denied with a "V" for unnecessary medical treatment based on a peer review; however, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Reimbursement is recommended in the amount of **\$15.00**. A referral will be made to Compliance and Practices as the carrier is in violation of Rule 129.5.

CPT code 98940 date of service 04-26-04 denied with denial code "D" (duplicate). Since neither party submitted an original EOB review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$31.35 (\$25.08 X 125%).**

CPT code 97140-59 date of service 04-26-04 denied with denial code "D" (duplicate). Since neither party submitted an original EOB review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$31.73 (\$25.38 X 125%).**

CPT code 97035 (2 units) date of service 04-26-04 denied with denial code "D" (duplicate). Since neither party submitted an original EOB review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$29.62 (\$11.85 X 125% = \$14.81 X 2 units).**

CPT code G0283 date of service 04-26-04 denied with denial code "D" (duplicate). Since neither party submitted an original EOB review will be per Rule 134.202. Reimbursement is recommended in the amount of **\$13.41 (\$10.73 X 125%).**

CPT code J2000 (2 units) date of service 05-04-04 denied with denial code "G/X006" (local infiltration, digital block or topical anesthesia is included in the value of the surgery procedure).

Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which service code J2000 was global to. Per Ingenix Encoder.Pro no coding conflicts were found for the services billed on 05-04-04. Reimbursement is recommended in the amount of **\$8.92 (\$3.57 X 125% = \$4.46 X 2 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 for dates of service 03-26-04 through 05-04-04 totaling \$1,304.64 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 Findings and Decision and Order are hereby issued this 24th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 5/20/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-2058-01
Name of Patient:	_____
Name of URA/Payer:	Neuromuscular Institute of Texas
Name of Provider: (ER, Hospital, or Other Facility)	Neuromuscular Institute of Texas
Name of Physician: (Treating or Requesting)	Brad Burdin, DC

May 10, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Carrier EOBs
2. Statement of Requestor's position, dated 4/28/05
3. Statement of Carrier's position, dated 5/2/05
4. Reevaluation narrative by treating doctor, dated 3/5/04
5. Radiology reports of cervical spine, left forearm, left shoulder, left wrist and left elbow, all dated 3/11/04

6. Treating doctor "Daily Treatment Logs," from 3/8/04 through 6/16/04
7. Letter of appeal to TWCC, dated 3/24/04
8. Required medical examination narrative, dated 4/8/04 and 5/27/04
9. Peer review, dated 4/9/04, with a reconsideration from same, dated 12/19/04
10. Treating doctor office visit narrative notes, dated 4/19/04, 4/23/04
11. Physical assistant's (from pain management medical doctor) office visit narrative notes, dated 3/30/04, 4/20/04, 5/4/04, and 5/27/04
12. Occupational therapy/testing scripts, dated 3/30/04, 4/20/04, 5/4/04 and 5/27/04
13. TWCC-73s, multiple dates

Patient is a 52-year-old female telephone operator for for 24 years, performing typing and data entry continuously. Her original injury was due to repetitive trauma and was dated as ____, and she originally treated with conservative chiropractic care, a right carpal tunnel release on 11/29/00, post-surgical therapy and rehabilitation, and was eventually returned to a full-duty work status. In July 2003, she began having a recurrence in her left upper extremity symptoms, specifically her hand and wrist, but it continued to worsen, and eventually extended proximally to her left shoulder and neck. She kept thinking it would go away, but when it did not, on 3/5/04, she returned to her treating doctor of chiropractic for additional treatment. Although the treating doctor initially reported it as a new injury, it was eventually determined instead to be a recurrence of the original injury. She was subsequently referred for four trigger point injections that occurred on 3/30/04, 4/20/04, 5/4/04 and 5/27/04, each followed by 6 sessions of post-injection therapy.

REQUESTED SERVICE(S)

Established patient office visits, levels II, III and IV (99212, 99213 and 99214), manual therapy technique (97140), ultrasound (97035), unattended electrical stimulation (G0283), paraffin baths (97018), therapeutic exercises, group (97150), therapeutic exercises (97110), and chiropractic manipulative therapy, spinal 1-2 areas (98940) from dates of service 3/26/04 through 6/16/04.

DECISION

The unattended electrical stimulations (G0283), the manual therapy techniques (97140), and the ultrasound treatments (97035) *from 3/26/04 through 5/3/04 only* are approved. In addition, the office visit, level III (99213) on 4/19/04 and the chiropractic manipulative therapy, spinal 1-2 areas (98940) on date of service 4/29/04, are approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

In this case, the medical records documented that the patient sustained a recurrence of her ___ injury. In fact, the carrier's RME doctor concurred with this determination. Therefore, it was both reasonable and appropriate for the treating doctor to perform periodic evaluations of the patient and the medical records documented that a reevaluation occurred on 4/19/04, so this was supported as medically necessary. Also, the treating doctor referred the patient for a trial of trigger point injections, followed by post-injection therapy. Since the medical provider who rendered the injections specifically recommended "ultrasound, e-stim, and soft tissue mobilization" (97035, G0283 and 97140, respectively) for the post-injection therapy, a trial of these services was supported as medically necessary. But no mention was made from the referring provider to perform paraffin baths (97018) or therapeutic exercises (97110), so the medical necessity of these services was unsupported. In addition, specifically regarding therapeutic exercises, nothing in the medical records supported the necessity of continued one-on-one supervised exercises (as opposed to a home-based exercise program), particularly when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises."¹

In addition, in terms of the ultrasound, "e-stim" and soft tissue mobilization performed after 5/3/04, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters*² Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. *Spine*. 2003 Feb 1;28(3):209-18.

² Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters*, Aspen Publishers, Inc.

trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Upon careful review of the medical records (specifically, the "Daily Treatment Logs"), it was noted that the patient began her care on 3/8/04 with a pain scale rating of "8/10," received her first injection on 3/30/04 with a pain scale rating of "7/10," and after a four-week trial of post-injection therapy (ending on date of service 5/3/04), she still reported a pain scale rating of "8/10". Additionally, this was the case despite the fact that the patient received her second injection on 4/20/04. In fact, even after a total of 4 injections and 29 therapy visits, the medical records reveal that her pain scale rating was still recorded at "8/10" on date of service 6/16/04. Therefore, since no objective or functional improvements was documented and since the TWCC-73s showed that the patient continued on total disability during this time, the records revealed that the treatment did not meet statutory requirements³ because the patient did not obtain relief, promotion of recovery was not accomplished, and there was not an enhancement of the employee's ability to return to employment.

Insofar as the established patient office visit, level IV, on date of service 4/23/04 was concerned, nothing in either the medical records or the diagnosis submitted in this case supported the medical necessity of performing such a high level of Evaluation and Management (E/M) service for this patient. In addition, the documentation for that date of service failed to meet the requirements for reporting this level E/M service CPT⁴.

And finally, regarding the remaining established patient office visits, level III (99213) on 3/26/04, 4/14/04, and 4/20/04 were concerned, these were not documented in either the doctor's narrative notes or the "Daily Treatment Logs" as having even occurred on those dates of service. Therefore, their medical necessary was unsupported. And in terms of the remaining established patient office visits, level II (99212), nothing in either the diagnosis or the records supported the performance of these services on a regular, "routine" basis, and particularly not during the course of an already-established treatment plan.

³ Texas Labor Code 408.021

⁴ *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised.* (American Medical Association, Chicago, IL 1999),