

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-7364.M5

MDR Tracking Number: M5-05-2075-01

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 07-14-04.

The IRO reviewed supplies/materials (99070), office visits (99212/99213/99215), manual therapy technique (97140), therapeutic exercises (97110), neuromuscular re-education (97112), therapeutic activities (97530), durable medical equipment (E1399-RR) rendered from 12-12-03 through 05-21-04 that were denied based upon "U" and "V".

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

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 04-13-05, 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 99070 dates of service 12-12-03 (\$50.00 and \$15.00 billed) and 03-02-04 (\$250.00 billed) 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 99070 was global to. Reimbursement is recommended in the amount of **\$315.00 (\$50.00, \$15.00 and \$250.00)**.

HCPCS code E0745-RR (neuromuscular stimulator) date of service 12-12-03 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix). The carrier has made a payment of \$111.89. Per the 2003 DMEPOS Fee Schedule the reimbursement is \$89.51 (with modifier RR (rental)). No additional reimbursement is recommended.

Review of CPT codes 64550-RR and 99070 date of service 12-12-03, code 99358-22 dates of service 02-18-04, 02-24-04, 03-01-04, 03-11-04, 03-17-04, 03-24-04 and 04-19-04, code 97112-59 date of service 03-02-04, code 99212 date of service 04-15-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing

evidence of carrier receipt of the providers request for EOBs. No reimbursement is recommended.

CPT code 97140-59 (29 units total) dates of service 12-16-03 (3 units), 12-30-03 (2 units), 01-02-04 (2 units), 01-14-04 (2 units), 01-15-04 (2 units), 01-16-04 (2 units), 01-28-04 (2 units),

02-10-04 (2 units), 02-12-04 (2 units), 02-13-04 (2 units), 02-17-04 (2 units), 02-26-04 (2 units), 03-02-04 (2 units), and 03-22-04 (2 units) denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix).

The carrier has paid \$87.89 on the 2003 services and \$710.64 on the 2004 services.

Reimbursement per Rule 134.202(c)(1) for the 2003 services is \$162.75 ($\$26.04 \times 125\% = \32.55×5 units). Additional reimbursement for the 2003 services is recommended in the amount of **\$74.86 (\$162.75 minus carrier payment of \$87.89)**. Reimbursement per Rule 134.202(c)(1) for the 2004 services is \$789.60 ($\$26.32 \times 125\% = \32.90×24 units). Additional reimbursement for the 2004 services is recommended in the amount of **\$78.96 (\$789.60 minus carrier payment of \$710.64)**.

CPT code 99358-22 dates of service 12-20-03 and 12-21-03 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 99358-22 was global to, however, modifier 22 is invalid per Ingenix Encoder.Pro.Com . No reimbursement is recommended.

CPT code 97140-59 dates of service 12-23-03 (2 units), 12-24-03 (2 units) and 01-22-04 (2 units) denied with denial code "N/X322" (documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge). The carrier has made no payment. The requestor submitted documentation to support the services delivered. Reimbursement for the 2003 services is recommended in the amount of **\$130.20 (\$26.04 X 125% = \$32.55 X 4 units)**. Reimbursement for the 2004 services is recommended in the amount of **\$65.80 (\$26.32 X 125% = \$32.90 X 2 units)**.

HCPCS code E1399-RR date of service 01-21-04 denied with denial code "C/Z561" (this preferred provider has agreed to reduce this charge below fee schedule or usual and customary charges for your business). The requestor did not provide proof that a contract did not exist, therefore, no reimbursement can be recommended.

CPT code 72020 (3 units) date of service 03-02-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix). The carrier has paid \$79.54. Per Rule 134.202(c)(1) reimbursement is \$88.38 ($\$23.57 \times 125\% = \29.46×3 units). Additional reimbursement is recommended in the amount of **\$8.84 (\$88.38 minus carrier payment of \$79.54)**.

CPT code 76880 date of service 03-12-04 denied with denial code "F/Z560" (the charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix). The carrier has paid \$62.27. Per Rule 134.202(c)(1) reimbursement is \$107.75 ($\$86.20 \times 125\%$). Additional reimbursement is recommended in the amount of **\$45.48 (\$107.75 minus carrier payment of \$62.27)**.

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 12-12-03 through 03-22-04 totaling \$719.14 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 11th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 10, 2005

To The Attention Of:

TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

RE: Injured Worker:

MDR Tracking #: M5-05-2075-01

IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed 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 Chiropractic reviewer who has an ADL certification. The reviewer 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Statement letter from the treating doctor
- Peer review reports
- Diagnostic exam reports
- Examination reports
- MMI report
- Referral notes
- Exercise sheets

Submitted by Respondent:

- None provided

Clinical History

According to the supplied documentation, it appears the claimant sustained an injury to his right ankle/foot when a large container slipped and rolled over his right foot. The claimant was treated at Concentra Health Care and underwent approximately 10 visits of physical therapy and at that time decided to change treating doctors to Carl M. Naehritz, III, D.C. Daily notes begun on 12/12/03 document passive and active modalities that last through 5/21/04. On 2/20/04 the claimant underwent a bone scan that revealed abnormal activity involving the right lateral malleolus. The claimant underwent an MRI of the right foot on 3/4/04 that revealed a 5-6mm focal fluid collection consistent with tendon avulsion or avulsive fragment, as well as small ankle joint effusion. There is also a previous MRI dated 9/18/03 that revealed a 1.5cm bone contusion of the lateral malleolar tip. No definite linear fracture was seen. The MRI reported there was likely a tear of the anteroinferior tibiofibular ligament and lateral malleolar ligaments tendinosis. The claimant underwent an ultrasonographic survey of the right ankle on 3/12/04 that revealed tenosynovitis of the extensor digitorum longus anterior to the lateral malleolus, there is a fluid collection at the tip of the lateral malleolus compatible with known history of ligamentous tear or avulsion injury. There were exercise sheets that recorded the daily active therapy submitted for review as well. The documentation ends here.

Requested Service(s)

99070 supplies and materials, 99213 office visit, 97140 manual therapy technique, 97110 therapeutic exercises, 97112 neuromuscular re-education, 97530 therapeutic activities, E1399 RR durable medical equipment, 99215 office visit, and 99212 office visit for dates of service 12/12/03 to 5/21/04

Decision

I agree with the insurance carrier that the services in dispute were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the claimant sustained an injury on _____. The objective documentation supplied including the MRI reports and bone scan appear that there is an injury consistent with the tendon avulsion or an avulsive fragment, this is also reported in the rebuttal of the peer review by Dr. Naehritz on 5/17/04. With this type of injury manual therapy as well as strenuous active therapy exercises that the treating chiropractor was using is not objectively supported. The objective documentation supplied contradicts the type of therapy the treating chiropractor was utilizing. A sample active therapy date on 2/12/04 revealed the claimant was undergoing exercises such as a trampoline for 5 minutes, step exercises, calf raises, and a wobble ball. The claimant reported a burning sensation in the right ankle during the calf raises. This type of strenuous exercise will be contraindicated in any avulsion style injury. These types of injuries should be completely healed prior to any conditioning style therapy. The supplied documentation is limited to treating doctor notes, a rebuttal letter and exercise sheets that do not objectively support the dates of service in question.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 10th day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder