MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (X) No
Requestor's Name and Address John Parker, D.C. 3719 N. Beltline Road Irving, Texas 75038	MDR Tracking No.: M5-05-2345-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address American Casualty Company Box 47	Date of Injury: Employer's Name: Insurance Carrier's No.:

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Did Requestor Prevail?
From	**To**		
03-03-04	**10-27-04**	**97530, 97110, 99199, 99213, A4570 and 99080 (denied for medical necessity)**	☐ **Yes** ☒ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

PART III: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Commission Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Medical Review Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

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

Date of service 02-20-04 per Rule 133.308(e)(1) was not timely filed and will not be a part of the review.

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 05-11-2005, 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 97530-GP dates of service 03-03-04 (5 units) and 03-04-04 (5 units) denied with denial code "G/509-001 (Unbundling/correct coding initiative bundle guidelines indicate this code is a mutually exclusive code considered included in another code on the same day. Per Medicare CPT code 97530 is mutually exclusive to CPT code 97150 which was billed on the same dates of service. No reimbursement is recommended.

CPT code 97530-GP dates of service 03-08-04 (4 units) and 03-10-04 (5 units) denied with denial code "E/855-009 (entitlement to benefits/the carrier is disputing coverage of the injury). The adjustor for the carrier was contacted on 06-08-04 and verified that the claim had been accepted and compensability issues had been resolved, however, CPT code 97530 per

Medicare is mutually exclusive to CPT code 97150 which was billed on the same dates of service. No reimbursement is recommended.

CPT code 97150 dates of service 03-08-04 (3 units) and 03-10-04 (3 units) denied with denial code "E/855-009 (entitlement to benefits/the carrier is disputing coverage of the injury). The adjustor for the carrier was contacted on 06-08-04 and notified TWCC that the claim had been accepted and compensability issues had been resolved. These services will be reviewed in accordance with Rule 133.307. Reimbursement is recommended in the amount of **$135.60 ($18.08 X 125% = $22.60 X 6 units).**

CPT code 99199 dates of service 03-08-04 and 03-10-04 denied with denial code "E/855-009 (entitlement to benefits/the carrier is disputing coverage of the injury). The adjustor for the carrier was contacted on 06-08-04 and notified TWCC that the claim had been accepted and compensability issues had been resolved. Reimbursement is recommended in the amount of **$50.00 ($25.00 X 2 DOS)** per Rule 134.202(c)(6).

CPT code 95900- WP (6 units) date of service 03-16-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has not made a payment. Reimbursement is recommended in the amount of **$511.86 ($68.25 X 125% = $85.31 X 6 units).**

CPT code 95904-WP (6 units) date of service 03-16-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has not made a payment. Reimbursement is recommended in the amount of **$435.60 ($58.08 X 125% = $72.60 X 6 units).**

CPT code 95861-WP (1 unit) date of service 03-16-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has not made a payment. Reimbursement is recommended in the amount of **$148.75 ($119.00 X 125%).**

Review of CPT code 95903-WP (4 units) date of service 03-16-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of the carrier's receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **$361.16 ($72.23 X 1235% = $90.29 X 4 units).**

CPT code 99242 date of service 03-16-04 denied with denial code "F" (Fee Guideline MAR reduction). The carrier has not made a payment. Reimbursement is recommended in the amount of **$118.11 ($94.49 X 125%).**

CPT code 95831-GP date of service 03-16-04 denied with denial code "G/509-001 (Unbundling/correct coding initiative bundle guidelines indicate this code is a mutually exclusive code considered included in another code on the same day. Per Medicare CPT code 95831-GP is a component of CPT code 99242. There are no circumstances in which a modifier would be appropriate. No reimbursement is recommended.

CPT code 95832-GP date of service 03-16-04 denied with denial code "G/509-001 (Unbundling/correct coding initiative bundle guidelines indicate this code is a mutually exclusive code considered included in another code on the same day. Per Medicare CPT code 95832-GP is a component of CPT code 99242. There are no circumstances in which a modifier would be appropriate. No reimbursement is recommended.

CPT code 93740 date of service 03-16-04 denied with denial code "G/855-013" (Unbundling/payment denied as the service is included in the global value of another billed procedure). Per Medicare code 93740 is not global to any other services billed on date of service 03-16-04. Reimbursement is recommended.

CPT code 99090 date of service 04-05-04 denied with denial code "G/855-013" (Unbundling/payment denied as the service is included in the global value of another billed procedure). Per Medicare CPT code 99090 is not global to other services billed on 04-05-04. Reimbursement is recommended.

CPT code 97530 dates of service 04-07-04 (5 units) and 04-23-04 (3 units) denied with denial code "F" (Fee Guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended in the amount of **$300.64 ($30.06 X 125% = $37.58 X 8 units).**

Review of CPT code 97110 date of service 04-07-04 revealed that the carrier provided an EOB, however, the EOB did not have an explanation code explaining the reason the service was denied. CPT code 97110 date of service 04-23-04 denied

with denial code "F" (Fee Guideline MAR reduction). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation. No reimbursement is recommended.

CPT code 99199 dates of service 04-07-04 and 04-23-04 denied with denial code "M/855-016" (No MAR/payment recommended at fair and reasonable rate $25.00). The carrier has made no payment. Reimbursement is recommended in the amount of **$25.00** per Rule 134.202(c)(6) .

CPT code 99213 date of service 08-27-04 denied with denial code "D" (duplicate bill). Since neither party submitted an original EOB the review will be per Rule 134.202. Reimbursement is recommended in the amount of **$68.24 ($54.59 X 125%).**

Review of CPT code 99213 date of service 10-07-04 revealed that neither party submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor submitted convincing evidence of the carrier's receipt of the providers request for an EOB. Reimbursement is recommended in the amount of **$68.24 ($54.59 X 125%).**

PART IV: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor **is** entitled to reimbursement for services involved in this dispute totaling $2,223.20 + $84.00 + $110.00. The requestor **is not** entitled to a refund of the paid IRO fee. The Division hereby **ORDERS** the insurance carrier to remit this amount and the appropriate amount for the services in dispute consistent with the applicable fee guidelines, plus all accrued interest due at the time of payment, to the Requestor within 20-days of receipt of this Order.

Findings and Decision and Order by:

		07-29-05
Authorized Signature		Date of Decision and Order

PART V: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

PART VI: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

Envoy Medical Systems, LP

1726 Cricket Hollow
Austin, Texas 78758

Phone 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 21, 2005

Re: IRO Case # M5-05-2345-01 ___

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed in Texas, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Explanation of benefits
3. TWCC 69 reports
4. RME 7/14/04, Dr. Tuinstra
5. Operative report 1/4/04, Dr. Van Hal
6. Requestor's position statement
7. TWCC initial report of injury
8. Parkland hospital records 1/14/04
9. Records, Dr. Kamal
10. Records, Dr. Johnson
11. Electrodiagnostic study 3/16/04
12. Reports, Texas Behavioral Health
13. Report 8/17/04, Dr. Van Hal
14. Medical reports and documentation, Dr. Parker
15. Treatment notes, Dr. Parker
16. TWCC work status reports
17. PPE reports 2/29/04, 3/30/04, 5/5/04
18. Job description for patient
19. Physical therapy evaluation

History
The patient reported injury of her wrists in ___ after repetitive use of her hands doing various jobs. She has been evaluated with x-rays, EMG and bone scan. She has been treated with chiropractic treatment and surgery.

Requested Service(s)
Therapeutic activities, therapeutic exercises, unlisted special srvc, OV, splint, copies 3/3/04 – 10/27/04

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient had an intense and adequate trial of conservative treatment prior to the dates in this dispute, without relief of symptoms or improved function. After conservative treatment failed, the patient underwent carpal tunnel release surgery on 11/4/04. I agree with another reviewer that if a patient remains symptomatic to the wrist with a working diagnosis of CTS after 20 sessions of chiropractic care and/or physical therapy, surgical management would be required to further reduce / ameliorate the symptoms. According to the documentation provided for this review the patient received some 20 treatments as of 3/4/04 without documented, objective or subjective improvement. As of 3/4/04 the patient still complained of severe weakness, constant sharp, shooting, stinging pain with tingling, soreness and weakness at a severe level in both wrists, hands and elbows. The patient also stated that there had been no change in her symptoms with treatment.
The treating D.C.'s notes are voluminous and highly repetitive. The treatment plan was vague, and without change, even when the patient failed to respond to the care. Months went by without relief of symptoms. The D.C. should have realized prior to the dates in this dispute that the treatment was not beneficial, and the patient should have been referred to a hand specialist for further treatment.
There is no indication in the notes provided for this review that the patient received any lasting objective benefit or subjective relief of symptoms. Even subjective pain complaints did not appear to be appreciably affected, despite the continuing treatment, with pain levels as high as 8/10 after several months of treatment.
The records provided present no identifiable reason why further monitored therapy was required as of 3/3/04. Treatment was extensive, not cost-effective, and did not show objective measurement of functional gain. The care failed to return the patient to work after about nine months of treatment. The continued failure of conservative treatment does not establish a medical rationale for additional non-effective therapy.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

_____
Daniel Y. Chin, for GP