

support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The requestor withdrew services which had been paid by the carrier.

CPT code 99214 on 9-7-04 was denied by the carrier as "G – this office visit is included in the value of the surgery."

Per the 2002 MFG "Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable." Recommend no reimbursement.

The carrier denied CPT Code 99080-73 on 9-10-04, 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. A referral will be made to Compliance and Practices for this violation. The Medical Review Division has jurisdiction in this matter; Recommend reimbursement of \$15.00.

The carrier denied CPT Code 99080-73 on 1-25-05, with a "U" for unnecessary medical treatment; and an "F – this charge has been reimbursed according to the appropriate fee schedule. However, the TWCC-73 is a required report per Rule 129.5 and is not subject to an IRO review. The requestor states that no payment as been made. Recommend reimbursement of \$15.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, Rule 129.5 and 2002 MFG.

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to a refund of the paid IRO fee. Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is entitled to additional reimbursement in the amount of \$30.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Findings and Decision and Order by:

Authorized Signature

Typed Name

9-21-05

Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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

September 14, 2005

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

Re: Medical Dispute Resolution
MDR #: M5-05-3077-01
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:dd

REVIEWER'S REPORT
M5-05-3077-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:

Medical Necessity Letter
Office Notes 01/29/01 – 04/12/05
PT Notes 04/29/04 – 06/14/05
Procedure Notes 06/22/04 – 03/22/05

Hand Surgery:
Office Notes 10/02/03 – 03/04/04

Clinical History:

This patient states that she had been employed with _____ for 6 years. She stated that she essentially kept the same occupation throughout these 6 years and also worked as a service rep. She states that her job makes her work constantly as far as typing with data entry on a keyboard. She reports that she works constantly with a headset and takes phone calls throughout the day. She also stated that she uses a 10-key calculator throughout the day, as well.

Disputed Services:

Office visits 99212, 99213, 99214, manual therapy technique 97140-59-GP, ultrasound 97035-GP, electrical stimulation G0283-GP, therapeutic exercises 97110, injection trigger points 3, 20553, bupivacaine H ml, S0020, syringe with needle A4209. Dates of services disputed are 08/24/04 through 02/03/05.

Decision:

The reviewer agrees with the determination of the insurance company and is of the opinion the services in dispute as stated above were not medically necessary.

Rationale:

This patient's date of injury of ____ and the dates of services disputed which were 08/24/04 through 02/03/05 appear to be severely protracted. The patient's diagnosis of carpal tunnel syndrome suggests that the window of opportunity has come and gone for the services that are disputed. These services are passive therapy visits. The ultrasound, the electrical stimulation, and trigger point injections, would be prudent to be used in the initial phase of care, according to the Texas Workers' Compensation Commission Upper Extremity Treatment Guidelines, rule 134.1002. Office visits of 99212, 99213, and 99214 are not medically necessary 3 years post injury. The level of these services 3 years later are not medically necessary and not reasonable. The manual therapy technique, 97140-59 was used as a modifier to unbundle the services in order to also bill the therapeutic exercises 97110. These manual techniques and therapeutic exercises would have been better served during the window of opportunity before this patient's condition became chronic. Most guidelines such as the Texas Workers' Compensation Commission Upper Extremity Treatment Guidelines rule 134.1002 and the Chiropractic Quality Assurance and Practice Parameters would support that no treatment is recommended for any kind of chronic condition to prevent the deleterious onset of physician-dependent somatization, continued chronicity, illness behavior, and deconditioning, all of which are adverse and lead to overutilization. The validity of the chiropractic treatment in this case should be quick and prudent. The TWCC rules that were stated by the treating doctor, rule 134.202A3, rule 134.10013B and 134.10013E, and rule 134.10012E1 cannot be misinterpreted to be given carte blanche treatment. The efficacy of the treatment must be reasonable and medically necessary. The services that were provided would be provided in the lower levels of care under a much shorter time frame and not protracted out as services 3 and 4 years post injury.

SCREENING CRITERIA/TREATMENT GUIDELINES, AND PUBLICATIONS UTILIZED:

1. The Texas Workers' Compensation Commission Upper Extremities Treatment Guidelines 134.1002
2. The Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters