

MDR Tracking Number: M5-02-3174-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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. There is still an unresolved fee dispute.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
11/30/01	97750-FC	\$500.00	\$ 0.00	V	\$100.00/hr; 5 hrs maximum	IRO Decision	IRO deemed the FCE was medically necessary; therefore, recommend reimbursement of \$500.00.
12/5/01 12/20/01	99213	\$ 50.00	\$ 0.00	V	\$ 48.00	IRO Decision	IRO deemed the office visit as medically necessary. Recommend reimbursement of \$ 48.00.
2/11/02 2/12/02 2/13/02 2/14/02 2/19/02 2/20/02 2/21/02 2/22/02	97545WC 97546WC 97545WC 97546WC 97545WC 97546WC 97545WC 97546WC 97545WC 97546WC 97545WC 97546WC	\$ 72.00 \$180.00 \$ 72.00 \$216.00 \$ 72.00 \$216.00 \$ 72.00 \$216.00 \$ 72.00 \$216.00 \$ 72.00 \$216.00	\$ 0.00	V	\$ 36.00/hr	IRO Decision	IRO deemed the work conditioning program as medically necessary. Recommend reimbursement as billed. \$ 72.00 x 8 = \$576.00 + \$180.00 + \$216.00 x 7 = \$1,512.00 = \$2,268.00.

<b>DOS</b>	<b>CPT CODE</b>	<b>Billed</b>	<b>Paid</b>	<b>EOB Denial Code</b>	<b>MARS (Maximum Allowable Reimbursement)</b>	<b>Reference</b>	<b>Rationale</b>
9/5/01	97150 97250 97265	\$ 27.00 \$ 43.00 \$ 43.00	\$ 0.00	F F F	\$ 27.00 \$ 43.00 \$ 43.00	96 MFG Med GR I A 10 a	<p>Carrier denied as “F - ...exceeding 2 hrs max/session requires DOP; 3 hrs total max/session.” None of these codes are timed codes; therefore, total time per session is not an issue. Patient office visit report supports 97250 and 97265.</p> <p>97150 is not supported in that the notes do not indicate what group activities were performed. The notes simply state, “Group therapeutic exercises to increase endurance, coordination, flexibility, and stamina.” Therefore, recommend reimbursement of \$43.00 + \$43.00 = \$86.00.</p>

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9/10/01 9/24/01 9/26/01 9/27/01 10/3/01 10/4/01	97150 97250 97265	\$ 27.00 x 6 days \$ 43.00 x 6 days \$ 43.00 x 6 days	\$ 0.00	N F F	\$ 27.00 \$ 43.00 \$ 43.00	96 MFG Med GR I A 10 a	<p>Carrier denied as “N – not appropriately documented...does not appear to substantiate level of service billed.” Group therapy is not supported in that the daily patient office visit reports do not indicate what group activities were performed. The notes simply state, “Group therapeutic exercises to increase endurance, coordination, flexibility, and stamina.” Therefore, no reimbursement recommended for 97150.</p> <p>Carrier denied as “F - ...exceeding 2 hrs max/session requires DOP; 3 hrs total max/session.” None of these codes are timed codes; therefore, total time per session is not an issue. Patient office visit reports support 97250 and 97265. Recommend reimbursement of \$43.00 + \$43.00 = \$86.00 x 6 = \$516.00.</p>

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
9/12/01	97150 97250 97265	\$ 27.00 \$ 43.00 \$ 43.00	\$ 0.00	F F F	\$ 27.00 \$ 43.00 \$ 43.00	96 MFG Med GR I A 10 a	<p>Carrier denied as “F - ...exceeding 2 hrs max/session requires DOP; 3 hrs total max/session.” None of these codes are timed codes; therefore, total time per session is not an issue. Patient office visit report supports 97250 and 97265.</p> <p>97150 is not supported in that the notes do not indicate what group activities were performed. The notes simply state, “Group therapeutic exercises to increase endurance, coordination, flexibility, and stamina.” Therefore, recommend reimbursement of \$43.00 + \$43.00 = \$86.00.</p>
9/14/01	97150	\$ 27.00	\$ 0.00	N	\$ 27.00	96 MFG Med GR I A 10 a	<p>Carrier denied as “N – not appropriately documented...does not appear to substantiate level of service billed.” Group therapy is not supported in that the patient office visit report does not indicate what group activities were performed. The notes simply state, “Group therapeutic exercises to increase endurance, coordination, flexibility, and stamina.” Therefore, no reimbursement recommended.</p>
9/19/01 10/1/01	97110	\$280.00 \$280.00	\$ 0.00 \$0.00	A N	\$ 35.00 ea 15min	96 MFG Med GR I A 10 a	<p>Preauthorization is not required for the first eight weeks of physical therapy. Patient office visit notes indicate physical therapy began on 9-4-01 making 9-19-01 the third week of treatment. Code 97110</p>

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
							<p>billed on 10/1/01 was denied as "N --- not appropriately documented...report does not substantiate level of service billed." Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of SOAH 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, 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 the Commission requirements for proper documentation. The MRD declines to order payment because there is no direct statement as to whether the physical therapist was conducting exclusively one-on-one sessions with the claimant; the patient office visit report does not clearly indicate activities that would require a one-on-one therapy session; and the medical conditions/symptoms presented do not mandate one-on-one therapy session. Therefore, no</p>

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
							reimbursement recommended.
9/21/01	97750MT	\$ 86.00	\$ 0.00	N	\$ 43.00 ea body area	96 MFG Med GR I E 3	Carrier denied as “N – not appropriately documented...testing not attached.” Form 97750-MTM supports testing to upper extremities. Compensable injury is to the bilateral wrists. Recommend reimbursement of \$43.00.
10/1/01	97150	\$ 27.00	\$ 0.00	N	\$ 27.00	96 MFG Med GR I A 10 a	Carrier denied as “N – not appropriately documented...does not appear to substantiate level of service billed.” 97150 is not supported in that the patient office visit report does not indicate what group activities were performed. The notes simply state, “Group therapeutic exercises to increase endurance, coordination, flexibility, and stamina.” Therefore, no reimbursement recommended.
11-1-01	99215	\$125.00	\$ 0.00	N	\$103.00	96 MFG E/M GR VI B	Carrier denied as “N – not appropriately documented...does not appear to substantiate level of service billed.” 99215 requires two of these three key components – comprehensive history, comprehensive exam, medical decision making of high complexity. Patient office visit report along with subsequent medical narrative report support comprehensive exam and medical decision making of high complexity. Recommend reimbursement of \$103.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
10/22/01	97750MT	\$129.00	0.00	R	\$ 43.00 ea body area	96 MFG Med GR I E 3	Carrier denied as "R – Extent of Injury. Does not appear to be injury related." The compensable injury is to the bilateral wrist. The Form 97750-MTM includes testing to the upper extremities. Therefore, extent of injury is not a valid denial and this date of injury will be reviewed per the MFG. Recommend reimbursement of \$ 43.00.
11/1/01	97750MT	\$129.00	\$ 86.00	N	\$ 43.00 ea body area	96 MFG Med GR I E 3	Computerized mechanical, isometric muscle testing to the compensable injury (bilateral wrists) was documented on 11-1-01. No additional reimbursement recommended.
TOTAL		\$2948.00	\$ 86.00				The requestor is entitled to reimbursement of \$3,693.00.

The Commission has determined that **the requestor prevailed** on the majority of the medical fees (\$3,693.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee.

The above Findings and Decision is hereby issued this 18<sup>th</sup> day of March 2003.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$3,693.00 plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order. This Order is applicable to dates of service 9/05/01 through 2/22/02 in this dispute.

This Order is hereby issued this 18th day of March 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/dzt

October 21, 2002

**Corrected**

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M5 02 3174 01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ developed carpal tunnel syndrome due to repetitive motion while at work. She reported this injury on \_\_\_. It was reported that her work duties included repetitive manual packing of boxes while at work. She states that she developed pain and numbness in both of her hands and fingers. She eventually changed her treatment to \_\_\_ from \_\_\_, which was disputed by the carrier.

\_\_\_ was treated with active and passive treatment by \_\_\_. \_\_\_ reviewed the case per the request of \_\_\_, the adjuster for Unitrin, on 9-13-2001. It was noted in her report that \_\_\_ was sent for an EMG that revealed findings consistent with left CTS. It was also noted that \_\_\_ did decline surgical treatment for the CTS. No records were reviewed of rehabilitative exercises prior to the surgical consideration. \_\_\_ opined that 4 weeks of chiropractic care might be beneficial. However, no mention of the appropriateness of rehabilitation is noted.

A pre-authorization request was submitted on January 2, 2002 for 30 sessions of work hardening. A FCE dated November 27, 2001 was attached to this request. The pre-authorization request was approved for 15 sessions with re-evaluation at that point for efficacy of care on 1-15-2002.

\_\_\_, of the billing department for \_\_\_, wrote a letter to \_\_\_ that the charges for January 21, 2002 to February 8, 2002 should be changed to work conditioning because the psychologist passed away on January 18, 2002. Pre-authorization was obtained for an additional 3 weeks of work hardening in February 19, 2002. \_\_\_ had \_\_\_ perform a subsequent FCE on March 21, 2002. She was improved in her functional abilities. \_\_\_ was able to return to work with restrictions as of March 28, 2002.

\_\_\_, for \_\_\_, in a letter dated October 9, 2002 stated that the position of \_\_\_ was that the services disputed were approved by pre-authorization as well as medically necessary and related to the compensable body areas.

#### DISPUTED SERVICES

Work conditioning, Functional Capacity Evaluations, Office Visits

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The Functional Capacity Evaluations were necessary to determine \_\_\_ current functional abilities and determine the appropriateness of rehabilitation. TWCC fee guidelines allow for up to 3 FCE's to be performed. \_\_\_ was off of work for a substantial amount of time. \_\_\_ required that these evaluations be performed to determine medical care and formulate an appropriate treatment plan.

The TWCC fee guidelines allow for an injured worker to have access to the treating doctor. The office visits were therefore appropriate. Rehabilitation was pre-authorized as detailed above by her treating doctor. The carrier determined these visits medically necessary prior to this review.

Work hardening was preauthorized as detailed above. However, the psychologist for the work hardening program passed away during the time of \_\_\_ program. \_\_\_ was not able to participate in the psychological aspect of the work hardening program. The documentation submitted reflects that work conditioning was billed and performed within the guidelines set by the TWCC and CARF. \_\_\_ condition improved from the care received. Work conditioning was determined to be medically necessary and a reasonable substitute for the work hardening was pre-authorized given the circumstances.

The care in question was pre-authorized and determined to be medically necessary prior to this review by the carrier. Retrospective review of pre-authorized care is not appropriate. The FCE as a diagnostic test was necessary to formulate a treatment plan for \_\_\_ condition.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,