

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 03-30-04.

The IRO reviewed office visits, therapeutic exercises, neurological re-education, functional capacity evaluation and therapeutic activities rendered from 11-12-03 through 12-15-03 that were denied based upon "V".

The IRO determined that the functional capacity evaluation 12-11-03 **was** medically necessary. The IRO determined that office visits, therapeutic exercises, neurological re-education and therapeutic activities from 11-12-03 through 12-15-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 07-02-04, 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 99212 dates of service 10-30-03, 11-06-03, 11-07-03 and 11-11-03 denied with denial code "R" (extent of injury). The carrier accepted compensability for the left wrist sprain. The diagnosis of wrist sprain was billed (842.0). The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$188.92 is recommended ($\$37.78 \times 125\% = \$47.23 \times 4 \text{ DOS}$).

CPT code 97112 (8 units total) dates of service 10-30-03, 11-06-03, 11-07-03 and 11-11-03 denied with denial code "R" (extent of injury). The carrier accepted compensability for the left wrist sprain. The diagnosis of wrist sprain was billed (842.0). The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$295.52 is recommended ($\$29.55 \times 125\% = \$36.94 \times 8 \text{ units}$).

CPT code 97530 (10 units total) dates of service 10-30-03, 11-05-03, 11-06-03, 11-07-03 and 11-11-03 denied with denial code "R" (extent of injury). The carrier accepted compensability for the left wrist sprain. The diagnosis of wrist sprain was billed (842.0). The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$364.80 ($\$29.18 \times 125\% = \36.48×10 units).

CPT code 97110 dates of service 10-30-03, 11-05-03, 11-06-03, 11-07-03 and 11-11-03 denied with denial code "R" (extent of injury). Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings 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 (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

CPT code 95831 date of service 11-05-03 denied with denial code "R" (extent of injury). The carrier accepted compensability for the left wrist sprain. The diagnosis of wrist sprain was billed (842.0). The requestor submitted relevant information to support delivery of service. Reimbursement in the amount of \$39.39 is recommended ($\$31.51 \times 125\%$).

CPT code 99211 date of service 12-10-03 review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's. The requestor submitted proof of resubmission to the carrier per Rule 133.308(f)(2)(3). Reimbursement in the amount of \$26.94 ($\$21.55 \times 125\%$) is recommended.

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 in accordance with the fair and reasonable rate in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.503(a) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-30-03 through 12-11-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 27th day of October 2004.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION
06/25/04

Revised Notice

June 3, 2004

Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2379-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional 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 TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

On 08/22/03, this female was lifting a tote box full of auto parts which was very heavy and immediately developed pain the left forearm and left wrist. She described her pain as constant aching with frequent episodes of muscle spasms and stated that lifting and repetitious movements worsen her pain. Her left wrist and arm were evaluated with x-rays and her treatment has included wearing a wrist brace, physical therapy and pain medication.

Requested Service(s)

Office visits, therapeutic exercises, neurological reeducation, function capacity evaluation and therapeutic activities from 11/12/03 through 12/15/03

Decision

It is determined that the functional capacity evaluation (FCE) performed on 12/11/03 was medically necessary. However, the office visits, therapeutic exercises, neurological reeducation and therapeutic activities from 11/12/03 through 12/15/03 were not medically necessary.

Rationale/Basis for Decision

It is medically appropriate for the provider to have implemented a FCE on 12/11/03 to establish a baseline of function to allow the accurate identification of functional restriction when returning the claimant to the workforce.

The provider has not shown efficacy for the prior course of therapeutics rendered from 09/08/03 through 11/11/03 and thus the efficacy of continued utilization of chiropractic/physical therapy applications is not clear from the reviewed medical record. There is no documentation in the medical record that warrants the continued any upper level therapeutic program.

Therefore, the functional capacity evaluation (FCE) performed on 12/11/03 was medically necessary. However, the office visits, therapeutic exercises, neurological reeducation and therapeutic activities from 11/12/03 through 12/15/03 were not medically necessary.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment