MDR Tracking Number: M5-04-2380-01

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 03-30-04.

The IRO reviewed work hardening, work hardening each additional hour and functional capacity evaluation rendered from 09-03-03 through 09-24-03 that were denied based upon "V".

The IRO determined that the functional capacity evaluation **was** medically necessary. The work hardening and work hardening each additional hour **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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

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 06-23-04, 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 **97110** date of service 07-15-03 denied with denial code "G" (global). The carrier did not specify which service code 97110 was global to. 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 **97545-WH-AP** dates of service 08-11-03, 08-14-03, 08-21-03, 08-22-03, 08-25-03, 08-27-03, 08-28-03, 08-29-03 and 09-02-03 (9 DOS) denied with denial code "F/70" (fee guideline MAR reduction). The requestor submitted relevant information for all dates of service in dispute to support delivery of service. The requestor billed a total of $1,152.00 ($128.00 1 unit X 9 DOS) Per the Medical Fee Guideline effective 08-01-03 reimbursement is $64.00 per hour for CARF providers. Reimbursement in the amount of **$576.00** is recommended.

CPT code **97546-WH-AP** dates of service 08-11-03, 08-14-03, 08-21-03, 08-22-03, 08-25-03, 08-27-03, 08-28-03, 08-29-03 and 09-02-03 (9 DOS) denied with denial code "F/70" (fee guideline MAR reduction). The requestor submitted relevant information for all dates of service in dispute to support delivery of service. The requestor billed a total of $2,816.00 ($320.00 5 units X 8 DOS and $256.00 4 units X 1 DOS). Per the Medical Fee Guideline effective 08-01-03 reimbursement in the amount of **$2,816.00** is recommended.

CPT codes **97545-WH-AP and 97546-WH-AP** date of service 08-26-03 denied with denial code "D" (duplicate billing). The requestor nor respondent submitted the original EOB. The Medical Review Division cannot determine the original reason for denial for these services therefore no reimbursement is recommended.

This Findings and Decision is hereby issued this 15th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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 Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(b); 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 08-11-03 through 09-03-03 in this dispute.

This Order is hereby issued this 15th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

Specialty Independent Review Organization, Inc.

Amended Report

October 12, 2004

David Martinez
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M5-04-2380-01
IRO #: 5284

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

Specialty 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 Specialty IRO 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 Specialty IRO 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

Mr.___ was injured on ___ by lifting a trash can while working for .. He initiated treatment with Dr. Larry Parent, D.C. on 5-03-03 and was diagnosed with a lumbar sprain/strain and lumbar disc disease without myelopathy. Office notes indicate a referral to Dr. James Laughlin, D.O. who recommended continued treatment. A MRI of the lumbar spine preformed on 6-05-03 showed a 2-3MM disc bulge at L5-S1 without neural compromise or stenosis. A NCS was performed on 6-10-03 that demonstrated bilateral L5 nerve root irritation, an EMG was apparently not performed. Dr. Parent treated Mr.___ with a combination of passive and active therapies and subsequently a work hardening program. An initial FCE was performed on 8-07-03 by Tony Bennett, D.C. that demonstrated Mr.___ to be at a medium physical demand category that met the patient's job physical demand category. There was some notable decrease in endurance and severe pain ratings on Oswestry test. Work Hardening was recommended for 30 sessions. An interim/final FCE was performed on 9-03-03, which appeared to be on the same day as a work hardening program was performed. The findings of this FCE showed that Mr.___ has remained in the medium physical demand category but improved to above average endurance and pain levels had decreased to mild to moderate by Oswestry and review of actual records. Pain levels appeared to decrease from approximately a 7/10 to stay at a 4/10. Mr.___ changed treating doctors on 9-22-03. The insurance carrier has denied treatment including and after 9-03-03 with the rationale of "unnecessary treatment (with peer review)."

DISPUTED SERVICES

The disputed items are: 97545-WH-AP-Work Hardening, 97546-WH-AP-Work Hardening-Each Add Hour and 97750-FC-Functional Cap Eval. The dates of service for the disputed items are 9-3-03 to 9-24-03.

DECISION

The reviewer agrees with the previous adverse determination regarding the work hardening and work hardening each addition hour. However, the reviewer disagrees with the previous adverse determination regarding the functional capacity evaluation.

BASIS FOR THE DECISION

Mr.___ received approximately 9 weeks of passive and active care followed by three weeks of work hardening before the FCE on 9-3-03. According to the FCE on 9-3-03 as well as the FCE on 8-07-03, Mr.___ had reached a medium physical demand level to sufficiently return to work. Additionally, Mr.___ had an above average performance on Bruce test with mild to moderate pain levels. The reviewer states that the patient had recovered sufficiently by 9-03-03 to return to work and therefore according to Texas Labor Code 408-021 a) further treatment would not be indicated. However, the FCE on 9-03-03 is reasonable to perform an interim FCE during a work hardening program to determine if further care is reasonable and necessary.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy.

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

Sincerely,

Wendy Perelli, CEO
CC: Specialty IRO Medical Director