

MDR Tracking Number: M5-05-0058-01

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 06/28/04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that CPT Codes 97545-WH-AP and 97546-WH-AP were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 September 15, 2004, 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 19 days of the requestor's receipt of the Notice.

- CPT Code 97545-WH-AP (6 units) for dates of service 07/21/03 through 07/23/03. EOBs submitted by the requestor did not report any payment exception codes and the respondent did not submit EOBs with their response to MDR; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (II)(C) and (E) reimbursement in the amount of \$384.00 (\$64.00 x 6) is recommended.
- CPT Code 97546-WH-AP (15 units) for dates of service 07/21/03 through 07/23/03. EOBs submitted by the requestor did not report any payment exception codes and the respondent did not submit EOBs with their response to MDR; therefore, these dates of service will be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (II)(C) and (E) reimbursement in the amount of \$960.00 (\$64.00 x 15) is recommended.
- CPT code 90801 for date of service 07/31/03. Neither party submitted EOBs. The requestor did not submit a HCFA-1500 for this service. Per Rule 133.307(e)(2)(A) MDR cannot determine if the requestor submitted this service for reconsideration in accordance with Rule 133.304. Reimbursement is not recommended.
- CPT Code 97545-WH-AP for dates of service 08/04/03 through 08/12/03 and 08/14/03 through 09/09/03. EOBs were either not submitted by both parties or the EOBs did not report any payment exception codes and the respondent did not submit EOBs with their responds to MDR; therefore, these dates of service will be reviewed according to Rule 134.202. Per Rule 134.202(e)(5)(A)(i) the requestor did not use the proper modifier. Reimbursement is not recommended.

- CPT Code 97546-WH-AP for dates of service 08/04/03 through 08/12/03 and 08/14/03 through 09/09/03. EOBs were either not submitted by the parties or the EOBs did not report any payment exception codes and the respondent did not submit EOBs with their responds to MDR; therefore, these dates of service will be reviewed according to Rule 134.202. Per Rule 134.202(e)(5)(A)(i) the requestor did not use the proper modifier. Reimbursement is not recommended.
- CPT Code 97750-FCE for date of service 09/09/04 denied as “A – Preauthorization not obtained”. Per Rule 134.600 a Functional Capacity Evaluation does not require preauthorization. Per Rule 134.202(e)(4) the requestor submitted the FCE report to support services were rendered as billed. The requestor billed 1 hour. According to the Medicare Fee Schedule times the 125% the participating amount is \$33.41. The respondent has paid this amount as reflected in the Table of Disputed Services; therefore, additional reimbursement is not recommended.
- CPT Code 90830 for date of service 09/29/03. Per the Ingenix Encoder.Pro this code was deleted from Medicare prior to 1998 and for reporting CPT Code 96100 should have been used. Per Rule 134.202(b) Texas Worker’s Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding. Reimbursement is not recommended.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) 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 date of service 07/21/03 through 07/23/03 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 Decision and Order is hereby issued this 29<sup>th</sup> day of October 2004.

Marguerite Foster  
 Medical Dispute Resolution Officer  
 Medical Review Division

MF/mf

Enclosure: IRO Decision

October 22, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-0058-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ----- external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The ----- physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 43 year-old female who sustained a work related injury on ----- . The patient reported that while at work she sustained an injury to her right thumb, wrist and forearm. The diagnoses for this patient have included right wrist sprain/strain grade II, DeQuervain's Tenosynovitis, median nerve neuritis, and myofascial pain syndrome. The patient has been treated with physical therapy and steroid injections. The patient had also participated in a work hardening program.

#### Requested Services

Work Hardening Program 97545/97546 from 7/28/03 – 8/13/03.

#### Documents and/or information used by the reviewer to reach a decision:

##### *Documents Submitted by Requestor:*

1. Initial FCE 7/8/03
2. Work Hardening Daily Flow Sheet/Progress Notes 3/3/03 – 9/9/03
3. Final FCE 9/9/03

##### *Documents Submitted by Respondent:*

1. SOAP Notes 6/2/03 – 8/22/03
2. Final Impairment Examination 3/7/03
3. SOAP Notes 4/28/03 - 11/21/03
4. Work Hardening Daily Notes 7/22/03 – 9/8/03
5. Elbow and Wrist Therapeutic Procedures Chart 6/4/03 – 6/20/03

## Decision

The Carrier's denial of authorization for the requested services is upheld.

## Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 43 year-old female with a work related injury to her right hand, wrist and thumb sustained on ----- . The ----- physician reviewer indicated that the main diagnoses for this patient included tenosynovitis and nerve entrapment. The ----- physician reviewer noted that the patient received multiple treatment modalities that included medication, physical therapy, steroid injections, and splinting. The ----- physician reviewer also noted that the patient underwent physical therapy from 4/3/03 through 6/13/03 and an FCE on 4/22/03. The ----- physician reviewer indicated that the patient was recommended for further physical therapy. The ----- physician reviewer noted that the patient underwent a second FCE on 7/8/03 and then participated in a work hardening program from 7/28/03 through 8/13/03. The ----- physician reviewer explained that there is no documentation provided describing cognitive or psychological deficits. The ----- physician reviewer indicated that that patient did not require a cognitive, behavioral, or therapeutic approach for rehabilitation to return to work. The ----- physician reviewer explained that the patient's main deficits were in her right upper extremity. The ----- physician reviewer also explained that the patient did not require a general conditioning program. The ----- physician reviewer further explained that work hardening/conditioning programs have been shown to reduce the number of sick days for patient's with chronic back pain. The ----- physician reviewer further explained that this patient's injury was to her right upper extremity. Therefore, the ----- physician consultant concluded that the work hardening program 97545/97546 from 7/28/03 – 8/13/03 were not medically necessary to treat this patient's condition.

Sincerely,

-----

State Appeals Department