

MDR Tracking Number: M5-05-1638-01

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 02-07-05.

The IRO reviewed the medical necessity of work hardening rendered from 03-29-04 through 05-19-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid 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 02-25-05, 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.

Review of CPT code 97750-FC (12 units) revealed that the Respondent provided an EOB, however, no reason code was provided for the denial of code 97750-FC. The carrier made a payment of \$107.10. Per Rule 133.304(c) "the explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)". Per Rule 134.202(c)(1) additional reimbursement is recommended in the amount of **\$304.50 (\$27.44 X 125% = \$34.30 X 12 units = \$411.60 minus carrier payment of \$107.10).**

Review of CPT code 97545-WH-CA dates of service 03-15-04, 03-16-04, 03-17-04, 03-18-04, 03-19-04, 03-22-04, 03-24-04, 03-25-04, 03-26-04 and 03-30-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended per Rule 134.202(5)(A)(i) in the amount of **\$1,280.00.**

Review of CPT code 97546-WH-CA dates of service 03-15-04, 03-16-04, 03-17-04, 03-18-04, 03-19-04, 03-22-04, 03-24-04, 03-25-04, 03-26-04 and 03-30-04 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. Reimbursement is recommended per Rule 134.202(5)(A)(i) in the amount of **\$2,960.00.**

Review of CPT code 97545-WH-CA dates of service 04-12-04, 04-13-04, 04-14-04 and 04-15-04 revealed that the Respondent provided EOBs, however, no reason codes were provided for the denial of code 97545-WH-CA. Per Rule 133.304(c) "the explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)". Reimbursement is recommended per Rule 134.202(5)(A)(i) in the amount of **\$512.00.**

Review of CPT code 97546-WH-CA dates of service 04-12-04, 04-13-04, 04-14-04, 04-15-04 and 04-21-04 revealed that the Respondent provided EOBs, however, no reason codes were provided for the denial of code 97546-WH-CA. Per Rule 133.304(c) "the explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)". Reimbursement is recommended per Rule 134.202(5)(A)(i) in the amount of **\$1,344.00.**

CPT code 97750-FC dates of service 04-16-04 and 05-12-04 denied with denial code "F" (reimbursement is being withheld as this procedure is considered integral to the primary procedure billed). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which

procedure code 97750-FC was considered integral to. Reimbursement is recommended in the amount of **\$400.00.**

CPT code 97545-WH-CA dates of service 04-28-04, 04-29-04, 05-04-04, 05-05-04, 05-13-04, 05-14-04, 05-17-04 and 05-18-04 denied with denial code "N" (peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or rules contained with the applicable AMA CPT/HCPCS coding guidelines). Documentation submitted by the requestor supports the services billed. Reimbursement is recommended in the amount of **\$1,024.00.**

CPT code 97546-WH-CA dates of service 04-28-04, 04-29-04, 05-04-04, 05-05-04, 05-13-04, 05-14-04, 05-17-04 and 05-18-04 denied with denial code "N" (peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or rules contained with the applicable AMA CPT/HCPCS coding guidelines). Documentation submitted by the requestor supports the services billed. Reimbursement is recommended in the amount of **\$3,072.00.**

This Findings and Decision is hereby issued this 21st day of April 2005.

Medical Dispute Resolution Officer
Medical Review Division

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 from 02-16-04 through 05-18-04 totaling **\$10,896.50** in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is hereby issued this 21st day of April 2005.

Medical Dispute Resolution
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|------------------------|
| TWCC Case Number: | |
| MDR Tracking Number: | M5-05-1638-01 |
| Name of Patient: | |
| Name of URA/Payer: | Buena Vista Workskills |
| Name of Provider: (ER, Hospital, or Other Facility) | Buena Vista Workskills |
| Name of Physician: (Treating or Requesting) | Thimios Partalas, DC |

March 22, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Available information suggests that this patient reports a work related foot injury on _____. The patient presented the next day to ER where x-rays demonstrated a closed calcaneal fracture. Orthopedic assessment was made with a Darryl Cuda, MD, on 11/20/03. CT scan ordered 11/25/03 confirms comminuted calcaneal fracture with extension into the subtalar joint. The patient later presents to a chiropractor, Thomas Partalas, DC, on 11/26/03 and is referred to another orthopedist Richard Wilson, MD, on 12/01/03. The patient is placed in a cast, given pain medication and returned to Dr. Partalas for active and passive physical therapy. On 02/05/04, the patient is seen by a podiatrist, Karry Ann Shebetka, DPM, and another CT scan is ordered due to persisting pain and dysfunction with weight bearing. On 02/16/04 an FCE is performed at Buena Vista Workskills physical therapy center with recommendations to begin a work hardening program. Available physical therapy documentation shows some daily exercise flow sheets, daily reports, group psychotherapy notes and weekly staffing reports. These appear to suggest that the patient is performing a general physical conditioning and exercise program with little or no emphasis on the nature of injury, specific return to work tasks, vocational counseling or work simulation. No specific functional work activities analysis appears to be made. A designated doctor evaluation is performed 04/26/04 by a podiatrist, Susan Erredge, DPM, suggesting that the patient has not reached MMI and should complete a work hardening program, in addition to being fitted with orthotic devices by podiatry consult, ice packs, NSAIDs, home exercise and reevaluation at conclusion of treatment. Follow up letter from Dr. Erredge from 08/04/04 suggests that the patient has been placed at MMI and that any additional physical therapy or work hardening would not appear to be of any further benefit.

REQUESTED SERVICE(S)

Determine medical necessity for requested Work Hardening Program 03/29/04 through 05/19/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Available records do appear to support medical necessity for an appropriate Work Hardening program as recommended by treating doctor and designated doctor. However, program performed Buena Vista physical therapy facility does not appear to meet TWCC guidelines for work hardening as defined. Available notes from the Buena Vista facility appear to suggest that the patient is placed into a non-specific, non-individualized exercise and conditioning program with emphasis on areas of function not related to reported injury or patient's vocation. Medical necessity and appropriateness for this type program (as performed) is **not supported**.

1. TWCC MFG guidelines for Work Hardening and Work Conditioning Programs; (Medicine GR); CARF, Commission on Accreditation of Rehabilitation Facilities, 1990 Standards Manual.

"Work hardening is a highly structured, goal-oriented, individualized treatment program designed to maximize an individual's ability to return to work... utilizing real or simulated work activities..."

3. Schonstein E, Kenny DT, Keating J, Koes BW. Work conditioning, work hardening and functional restoration (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.