Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	MDR Tracking No.: M5-05-3176-01
Injury One Treatment Center 5445 La Sierra Dr., Suite 204 Dallas, Texas 75231	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address:	Date of Injury:
Employers Insurance Company of Wausau, Box 28	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 package. Position summary states, "Again, we are asking Wausau to reprocess this claim, the services rendered were medically necessary and were directly related to the work related injury that occurred on ___. This patient's recovery would have been negatively impacted without these treatments."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents include the DWC 60 response. Position summary states, "The peer review was mailed to the requestor on 2-10-05."

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
11-18-04 – 1-10-05	CPT code 97750-FC	☒ Yes ☐ No	0 - see below
11-18-04 – 1-10-05	CPT codes 97545-WH-CA, 97546-WH-CA	☐ Yes ☒ No	0

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

The Division has reviewed the enclosed IRO decision and determined that the requestor did not prevail on the disputed medical necessity issues.

Regarding CPT code 97750 on 3-24-05 and 5-13-05: The IRO did find these services necessary. Per Rule 134.202(e)(4): "A maximum of three FCE's for each compensable injury shall be billed and reimbursed. Reimbursement shall be for up to a maximum of four hours for the initial test, a maximum of two hours for an interim test, and a maximum of three hours for the discharge test. Documentation is required." The insurance carrier has already reimbursed the requestor for four FCE's. (The requestor states that it has been reimbursed for the FCE on 5-13-05.) The requestor provided no documentation per the Rule. No additional reimbursement recommended.

Based on review of the disputed issues within the request, the 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 Medical Dispute Resolution.

On 8-26-05 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.

CPT code 97750-FC on 12-16-04 was denied as "560-The charge for this service exceeds the fee schedule." The carrier provided proof that it did reimburse the requestor for eight units. Per Rule 134.202(e)(4) no additional reimbursement recommended.

CPT codes 97545-WH-CA and 97546-WH-CA on 1-13-05 were denied by the carrier as "X-170-Preauthorization was required, but not requested for this service." The requestor is a CARF accredited facility. Preauthorization for the Work Hardening Program is not required. Per Rule 133.308(p)(5) An IRO decision is deemed to be a commission decision and order. The IRO reviewer has denied the work hardening program. No reimbursement is recommended for 1-13-05.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.308, 134.202(c)(1), 134.202(e)(4)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute and is not entitled to a refund of the paid IRO fee.

Findings and Decision by:

		1-31-06
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

September 19, 2005

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

Patient:
TWCC #:
MDR Tracking #: M5-05-3176-01
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 Chiropractor. The reviewer is on the TWCC ADL. 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

According to the records available for review, Ms. ___ was injured in a work related accident on ___ while working for . The patient was moving batteries weighing approximately 50 lbs. on a cart for her employer when she experienced low back pain. She initially continued working and later presented for medical care.

Records were received from the insurance carrier and from the treating providers.

Records included but were not limited to:
Medial Dispute Resolution paperwork
Multiple EOB's
Notice of Disputed Issue and Refusal to Pay Benefits from the Carrier
Review from PRI—Dr. Sage
Report from Dr. Perkins—MMI/IR at 5% on 5-26-2004
Review from PRI—Dr. Sato
Reconsideration report from Dr. Sato
RME from Dr. Blair
IME from Dr. Blair
Report from Dr. Bishop
Field Investigator WC Investigation Report
Summary of Requestor's Position from Injury One Treatment Center
Request for Reconsideration letters from Injury One Treatment Center
Pre-authorization reports for Chronic Pain Management
Records from Injury One Treatment Center

Report from Texas Health

Numerous Chronic Pain Management records after the Dates of Service under review
Physical Therapy Evaluation by Arlene Henderson
Records from James Butcher
Report from Dr. Long
Reports from Phil Bohart
MRI from Advanced Medical Imaging
CT Discograph by Providence Health Center
Reports from Dr. Oishi

DISPUTED SERVICES

The items in dispute are the retrospective medical necessity of 97545 WH CA and 97546 WH CA – work hardening program and 97750-FC-FCE from 12/28/2004 through 5/13/2005.

DECISION

The reviewer agrees with the previous adverse determination regarding the work hardening 97545 and 97546 for all dates of service under review.

The reviewer disagrees with the previous adverse decision regarding the FCE 97750 for all dates of service under review.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, 1996 Medical Fee Guidelines specific to Work Hardening, Industrial Rehabilitation-Techniques for Success, and Occupational Medicine Practice Guidelines. Specifically, a Work Hardening program should be considered as a goal oriented, highly structured, individualized treatment program. The program should be for persons who are capable of attaining specific employment upon completion of the program and not have any other medical, psychological, or other condition that would prevent the participant from successfully participating in the program. The patient should also have specifically identifiable deficits or limitations in the work environment and have specific job related tasks and goals that the Work Hardening program could address.

It is clear from the records that the patient had identifiable conditions that would limit the patient's participation in a work hardening program. There is documentation in the records of positive Waddell's signs and subjective complaints that do not match the objective findings. There are also notations in the work hardening documentation that shows that the patient was self-limiting during the program due to her pain levels. There are also notations in the documentation that the patient had left wrist and left hand pain and was unable to participate fully in the program while she was at the program. In other words the patient attended the program but did not perform the activities of the program while she was there. The documentation reflects that due to the patient's pain levels and injury to her wrist she did not perform the activities of the program. This would be a condition that would prevent the patient from successfully completing the program. The entrance criteria to the program are also not clearly met in that there is no specific job that the patient is returning to. After completion of the work hardening program, a chronic pain program was initiated by the same facility. There are notations in the records that the patient would be a candidate for work hardening and it is apparent that the patient could have been directly placed in the chronic pain program due to her focus on pain and subjective complaints. In Dr. Bohart's report 7 out of the 11 subjective categories measured actually increased rather than decreased after the work hardening program. In other words, the patients self reported condition worsened. It should also be noted that the patient was placed at MMI with a 5% IR on 5-26-2004.

The FCE's would be medically necessary to establish the patient's functional abilities and as a guide for treatment rendered. The FCE's would also be used to determine return to work status. It appears that more than three FCE's were performed over the course of care but due to the protracted nature of ___'s care, the FCE's would be necessary to determine the patient's status.

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. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

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