

MDR Tracking Number: M5-02-2137-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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 the only issue** to be resolved. The functional capacity evaluations were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
03/29/01	95900WP	190.00	0.00	U	\$64.00 x 2 = \$128.00	IRO decision	The IRO determined this NCV was not medically necessary and therefore not reimbursable.
04/12/01	95904WP	\$380.00	0.00	U	\$64.00 x 4 = \$256.00	IRO decision	The IRO determined this NCV was not medically necessary and therefore not reimbursable.
04/26/01	97750FC	\$200.00	\$0.00	U	\$200.00	§133.1(a)(8)	The IRO determined this FCE was medically necessary. The carrier did not object to fair and reasonable reimbursement, therefore, reimbursement is recommended as billed, \$200.00.
06/21/01	97750FC	\$200.00	\$0.00	U	\$200.00	§133.1(a)(8)	The IRO determined this FCE was medically necessary. The carrier did not object to fair and reasonable reimbursement, therefore, reimbursement is recommended as billed, \$200.00.
TOTAL		\$970.00					The requestor is entitled to reimbursement of \$400.00.

On this basis, the total amount recommended for reimbursement (\$400.00) represents a majority of the medical fees of the disputed healthcare and therefore, the requestor prevailed in the IRO decision. Consequently, the requestor is owed a refund of the paid IRO fee.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees (\$400.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay \$400.00 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 dates of service 03/29/01 through 06/21/01 in this dispute.

This Order is hereby issued this 28th day of May, 2002.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 17, 2002

Re: IRO Case # M5-02-2137-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurology. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The ___ reviewer who reviewed this case has determined that, based on the medical records provided, part of the requested treatment was medically necessary and part of it was not medically necessary. Therefore, ___ disagrees in part and agrees in part with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as

follows:

This case involves a 58-year-old male who injured his back on _____. The patient underwent lower extremity evaluation in March and April, 2001 for a complaint of increased falling and weakness. The patient then had surgery in April, 2001. Two functional capacity evaluations were performed in April, 2001 and June, 2001.

I agree with the carrier's decision that the nerve conduction studies were not medically necessary.

I disagree with the carrier's decision to deny the functional capacity evaluations.

The nerve conduction studies performed were insufficient evaluations to determine the source of his injury. The motor study looked only at one muscle and tried to make a global determination based on one muscle, (including a questionable sensory determination). The sensory study looked only at the L4 and L5 dermatomes, and only the superficial peroneal nerve. In fact, the myelogram determined that the vertebrae involved were L2-3, not L4-5 or L5-S1. The sensory study was insufficient to make a determination.

A functional evaluation was reasonable to determine the patient's work ability.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

President