

MDR Tracking Number: M5-02-2316-01

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 did not clearly determine 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 initial functional capacity evaluation was found to be medically necessary. The work hardening program and subsequent functional capacity evaluation were not medically necessary.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
8-27-01	97750-FC	\$500.00	\$0.00	U	\$100/per hour	IRO decision	The IRO determined the initial FCE was medically necessary and therefore reimbursable. Recommend reimbursement of \$500.00.
10-17-01	97750-FC	\$200.00	\$0.00	U	\$100/per hour	IRO decision	The IRO determined the subsequent FCE was not medically necessary and therefore not reimbursable. No reimbursement is recommended.
9-4-01 thru 10-12-01	97545-WH and 97546-WH	\$10,880.00	0.00	U	\$64/hr minus 20% for non-CARF	IRO decision	The IRO determined that the work hardening program was not medically necessary and therefore not reimbursable. No reimbursement is recommended.

TOTAL	\$11,580.00	\$0.00	The requestor is entitled to reimbursement of \$500.00.
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On this basis, the total amount recommended for reimbursement (\$500.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of 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 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 8/27/01 in this dispute.

This Order is hereby issued this 17th day of October 2002.

Dee Z. Torres  
 Medical Dispute Resolution Officer  
 Medical Review Division

DZT/dzt

NOTICE OF INDEPENDENT REVIEW DECISION

September 20, 2002

Rosalinda Lopez  
 Program Administrator  
 Medical Review Division  
 Texas Workers Compensation Commission  
 4000 South IH-35, MS 48  
 Austin, TX 78704-7491

RE: MDR Tracking #: M5-02-2316-01  
 IRO Certificate #: 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in physical medicine and rehabilitation which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating 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 the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 36 year old female sustained a work-related injury on \_\_\_ when she was lifting two cases of bottles. She was initially treated with cortisone injections and physical therapy. The patient underwent an MRI that revealed a tear in the annulus of the disc. She ultimately underwent an initial functional capacity examination, a work hardening program and a final functional capacity examination.

### Requested Service(s)

A 97550-FC-functional capacity evaluation dated 08/27/01 and 10/17/01 along with 97545-WH and 97546-WH-work hardening 09/04/01 through 10/12/01.

### Decision

It is determined that the initial 97550-FC-functional capacity evaluation dated 08/27/01 was medically necessary to treat this patient's condition. However, it is determined that the 97550-FC-functional capacity evaluation dated 10/17/01 along with 97545-WH and 97546-WH-work hardening 09/04/01 through 10/12/01 were not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The patient underwent a functional capacity evaluation on 08/27/01 and then again on 10/17/01, at which time she had completed approximately 6 weeks of a work hardening program. In comparing the initial functional capacity examination and the final functional capacity examination, there is no significant difference to indicate any major change had taken place for the six weeks of work hardening that she had undergone. The values are essentially the same for both functional capacity evaluations based on the data supplied in the medical record documentation. In addition, based on the medical record documentation, there is no significant change from the beginning to the ending pain report. There is slight improvement noted in the productivity from the initial to final report. There is no essential difference noted in spine mobility measured by range of motion. There is no indication of any benefit that this patient received during the course of the work hardening program to establish any medical necessity. It is medically reasonable and necessary that an initial functional capacity evaluation would have been done at this point in time in order to establish the injured worker's status. Therefore, the initial functional capacity performed on 08/27/01 was medically necessary.

The work hardening program and the final functional capacity evaluation of 10/17/01 were not medically necessary based on the primary factor that this patient was not a suitable candidate for a work hardening program. In addition, there was no evidence of patient improvement from the

treatment that was provided. It is also noted \_\_\_ was pursuing invasive injection therapy at or about the time of the early phases of this work hardening program. This leads to the conclusion that the pain treatment element had not provided a significant enough improvement to enable the patient to gain benefit from participation in an intensive work hardening program.

Therefore, the initial 97550-FC-functional capacity performed on 08/27/01 was medically necessary. However, the 97550-FC-functional capacity evaluation dated 10/17/01 along with 97545-WH and 97546-WH-work hardening 09/04/01 through 10/12/01 were not medically necessary to treat this patient's condition.

Sincerely,