THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-3304.M5

MDR Tracking Number: M5-02-3098-01

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 not the only issue** to be resolved. There are unresolved fee issues.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12/31/01	97750-FC	$500.00	0.00	U	$100.00/hr	IRO Decision	The IRO determined this service was not medically necessary and therefore not reimbursable.
1/2/02 through 1/9/02	97545WHAP 97546WHAP	$130.00 x 6 $325.00 x 6	0.00	V	$64.00/hr	IRO Decision	The IRO determined this service was not medically necessary; therefore, no reimbursement is recommended.

1/10/02 through 1/17/02	97545WHAP 97546WHAP	$130.00 x 6 $325.00 x 6	0.00	A, Z		Rule 134.600 (e) & (h) (11); 96 MFG II E	Carrier used denial codes "A, 240 - preauthorization not obtained and "903 – Z Preauthorization requested but treatment/services denied." HCFAs document a preauthorization number; however, no written approval was submitted; therefore, preauthorization cannot be substantiated. No reimbursement recommended.
1/18/02 through 1/31/02	97545WHAP 97546WHAP	$130.00 x 6 $325.00 x 6	0.00	V		IRO Decision	The IRO determined this service was not medically necessary; therefore, no reimbursement is recommended.
1/31/02	97750-FC	$100.00	0.00	No EOB	$100.00/hr	96 MFG Med GR I E 2	Exit FCE was not documented. No reimbursement recommended.
TOTAL		$10,545.00	0.00				The requestor is not entitled to reimbursement.

On this basis, the total amount recommended for reimbursement ($ 0.00) 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.

The above Findings and Decision is hereby issued this 15th day of April 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

December 16, 2002 **CORRECTED REPORT 02/14/02**

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5-02-3098-01
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This male claimant injured his right wrist on ___. The right distal radius was fractured and was surgically repaired with bone grafting and a stabilization plate. The patient then received four months of rehabilitation after the surgery before the work hardening in question.

Disputed Services:
Work hardening program and FCE from 12/31/01 through 01/31/02.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the program **and FCE** in question were not medically necessary in this case.

Rationale for Decision:
This patient had been through four months of active rehabilitation and work conditioning prior the requested work hardening program, with some objective progress. Subjective reporting showed little

change over the period from August through December. The *Guidelines* indicate that a course of sixteen weeks of therapy should be adequate to address the injury and subsequent surgery from this injury.

After this four-month trial of care, the patient should have reached MMI or been referred for alternative care to aid him in reaching that MMI. The natural history of his condition has allowed the injury to reach maximum therapeutic benefit.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,