

MDR Tracking Number: M5-04-1695-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 February 10, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The manual therapy technique and work hardening denied with U from 09-08-03 through 11-06-03 **was** medically necessary. The IRO agrees with the previous determination that the manual therapy technique and work hardening program denied with V from after 11-06-03 **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 3, 2004, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT CODE | Billed | Paid | EOB Denial Code | MAR\$/ RVU\$ (Max. Allowable Reimbursement) | Reference | Rationale |
|------------------------------|----------------------------------|-----------------------|-----------------------|------------------|---|--------------------------|---|
| 10-16-03 thru 10-29-03 | 97545- WHCA 97546- WHCA | \$640.00 \$2176.00 | \$307.40 \$1228.84 | No EOB & F | \$64.00/hr x 10 \$64.00/hr x 34 | Rule 134.202(e)(5)(A) | TWCC records indicate the Requestor is a CARF accredited facility for a work hardening program. Therefore, the work hardening program billed from 10-16-03 thru 10-29-03 will be reviewed in accordance with the Medicare Fee Schedule. Recommend additional reimbursement of \$1279.76 |

| | | | | | | | |
|----------------------|--------------|------------------|----------|---|-----------------------------|--|---|
| 11-05-03 11-06-03 | 97750- FC | 295.52 295.52 | \$400.00 | M | \$36.94/each 15 min x 16 | Rule 134.202(c)(1) Rule 134.202(e)(4) | The conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. Therefore in accordance with the Medicare Fee Schedule recommend additional reimbursement of \$191.04. |
| TOTAL | | \$3407.04 | | | | | The requestor is entitled to reimbursement of \$1470.80. |

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 in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 for dates of service 09-08-03 through 11-06-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 3rd day of December 2004.

Patricia Rodriguez
 Medical Dispute Resolution Officer
 Medical Review Division
 PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

April 23, 2004

Rosalinda Lopez
 Program Administrator
 Medical Review Division
 Texas Workers Compensation Commission
 7551 Metro Center Drive, Suite 100, MS 48
 Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-1695-01
IRO Certificate #: IRO4326

The ___ 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 Rule §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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. ___'s health care professional 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 47 year old male was hit in the forehead by construction equipment and fell back striking his right shoulder on ___. At that time, he had MRI/CT scan(s) of the head and MRIs of the cervical spine and shoulder, which were all normal. An EMG study revealed mild right ulnar neuropathy, but a normal neurological examination. The treatment plan included home exercises, heat manipulation, massage, muscle relaxants, physical therapy, work hardening and nerve conduction velocity. He was release to light duty on 05/27/03, and full duty without restrictions on 08/04/03. The patient continued to complain of headaches and neck pain. On 10/06/03, he entered the work hardening program. On 10/17/03, and the EMG was performed, which showed "no electrophysiological evidence of cervical radiculopathy, brachial plexopathy, or distal mononeuropathy.

Requested Service(s)

Manual therapy technique and work hardening program from 09/08/03 through 11/13/03

Decision

It is determined that the manual therapy technique and work hardening from 09/08/03 through 11/06/03 were medically necessary. The manual therapy technique and work hardening after 11/06/03 were not medically necessary.

Rationale/Basis for Decision

The review of the medical records provided revealed that the patient had little physical therapy prior to his change of treating doctors and the initial course of manual therapy and work hardening was medically necessary in light of the patient's deficient functional capacity. However, as there was no change in the patient's physical demand capacity noted on the interim Functional capacity evaluation (FCE) performed on 11/06/03. Further work hardening was not indicated or medically necessary. Therefore, the manual therapy techniques and the work hardening from 09/08/03 through 11/06/03 were medically necessary. The manual therapy technique and the work hardening after 11/06/03 were not medically necessary.

Sincerely,