

MDR Tracking Number: M5-04-2014-01

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 3-8-04.

The IRO reviewed work hardening program.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid 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 5-4-04, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
10/30/03 11/13/03 11/14/03	97545-WH-CA 97546-WH-CA(6)	\$128.00 x 3 days \$384.00 x 3 days	\$0.00	A	\$64.00/hr if CARF	Rules 134.202(5)(C)(i)(ii) and 134.600(h)(9)	CARF accredited programs do not require preauthorization. Requestor submitted proof of CARF accreditation. Recommend reimbursement of \$128.00 + \$384.00 = \$512.00 x 3 days = \$1,536.00
TOTAL							The requestor is entitled to reimbursement of \$1,536.00

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 the fair and reasonable rate as set forth in Commission Rules 133.1(a)(8) and 134.202 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 10-30-03, 11-13-03, and 11-14-03 in this dispute.

This Order is hereby issued this 15th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

April 29, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2014-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 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.

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.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. 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 the area of Orthopedic Surgery who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services & EOB's
Letter of medical necessity (11/18/03), prior exams and reviews
Psychological screening (10/23/03)
Chiropractic and Orthopedic office notes
FCE and physical therapy notes 07/03 thru 12/03
Operative report 01/16/03 and MRI right knee 12/24/02

Clinical History:

This patient sustained an on the job injury on ___ and subsequently underwent arthroscopy in January of '03, including a lateral meniscectomy and chondroplasty and microfracture of the patellofemoral and tibial articulating surfaces along with a synovectomy. He subsequently underwent rehab after that procedure.

Disputed Services:

Work hardening/conditioning-initial and work hardening/conditioning-each additional hour during the period of 10/23/03 through 12/02/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the work hardening/conditioning program in dispute was not medically necessary in this case.

Rationale:

The reasons for the above decision are that the patient had extensive therapy and should be able to continue a home program. It is also unknown what level of therapy is anticipated or will be beneficial as apparently the patient is not working nor does he have a job that has been designated for him to go to.

Sincerely,