

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on 7-13-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that work hardening initial work hardening, each additional hour and functional capacity evaluation from 8-7-03 through 12-18-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

As the services listed above were not found to be medically necessary, reimbursement for dates of service 8-7-03 through 12-18-03 are denied and the Medical Review Division declines to issue an Order in this dispute.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only issue to be resolved.

In accordance with Rule 130.2 (a), A treating doctor shall either examine the injured employee (employee) and determine if the employee has any permanent impairment as a result of the compensable injury as soon as the doctor anticipates that the employee will have no further material recovery from or lasting improvement to the work-related injury or illness, based on reasonable medical probability, or have another authorized doctor do so.

According to the TWCC Rule 134.202 (e)(6)(C)(i) an examining doctor who is the treating doctor, shall bill using the 'Work related or medical disability examination by the treating physician...'. (I) Reimbursement shall be the applicable established patient office visit level associated with the examination; (II) modifiers "V1, V2, V3, V4, or V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit. In accordance with rule 134.202 (e)(6)(D)(III), If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100% of the total MAR.

According to the TWCC Rule 134.202 (e)(6)(D)(II)(-b-)(-1-), "If a full physical evaluation, with range of motion, is performed: \$300 for the first musculoskeletal body area;" According to the TWCC Rule 134.202 (e)(6)(D)(II)(-a-), "\$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." A review of the Requestors' MMI/IR evaluation report dated 10-07-03, revealed the examining doctor performed the MMI/IR evaluation on the right knee (\$300.00). The Requestor billed the above services using CPT code 99455 WP V3, for a total amount of \$345. The Requestor is therefore entitled to reimbursement in the amount of \$411.13. According to Rule 134.202(d), reimbursement shall be the least of the MAR amount as established by this rule. **Therefore recommend reimbursement of \$340.**

Pursuant to 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.

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 Decision and Order is hereby issued this 4th day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 7, 2004

AMENDED DECISION

RE:

MDR Tracking #: M5-04-3881-01

IRO Certificate #: 5242

_____ 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 proposed 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 Chiropractic reviewer who has an ADL certification. The 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.

Submitted by Requester:

- Affidavit of Custodian of the Records,
- MDR Request dated 7/5/04 from _____,
- Letter of Medical Necessity dated 12/8/03 from _____,
- Medical Dispute Resolution Request/Response,
- Table of Disputed Services dates 8/7/03-12/18/03,
- Health Insurance Claim Forms dates 8/7/03-12/18/03 from _____,
- Explanation of Review for dates of services 8/7/03-12/18/03,
- Health Insurance Claim Forms dates 8/7/03-12/18/03 from _____ request for reconsideration,
- Impairment Rating dated 10/13/03 from _____,
- _____ WC/WH Program Daily Notes with Visit Log Report dates 8/11/03-9/25/03

- _____ Daily Therapy Notes dates 5/7/03-7/31/03,
- _____ Patient Release Worksheet,
- _____ Psychology Group Note dates 8/11/03-9/23/03,
- _____ Saunders Exercises, Active Rehab Exercise/Fee Slip 5/7/03-6/6/03,
- Impairment Rating dated 10/7/03,
- Required Medical Examination dated 9/8/03 from _____,
- Employee Notification of Availability of Temporary Modified Work dated 10/8/03,
- Discharged Patient Quality Improvement Survey,
- Final FCE dated 9/29/03 from _____,
- _____ Notes _____ Pg321-328,
- Interim FCE dated 9/5/03 from _____,
- _____ dated 8/21/03,
- Peer Review dated 6/23/03 from _____,
- Psychosocial Screening dated 8/7/03 from _____,
- _____ Work Program, Patient Rights & Responsibilities, Program Policies, Patient Orientation, Education List, Resource List,
- Initial FCE dated 8/7/03 from _____,
- Stress and Lifestyle Change Survey dated 8/7/03,
- _____ Re-evaluation dated 7/7/03,
- _____ Initial Evaluation dated 5/7/03,
- Work Program Participant Intake Sheet,
- Notes 5/7/03-8/29/03,
- Pre-Op Instructions dated 6/10/03,
- EMG/NCV dated 9/15/03 from _____,
- MRI of the right knee dated 4/9/03 from _____,
- Intake Medical Report from _____,
- Radiographic Report of bilateral knees,
- Evaluation Report dated 4/24/03 from _____,
- Re-Evaluation Report dated 6/23/03 from _____,
- Accident and Injury Evaluation from _____,
- Daily Progress Notes 4/4/03-5/2/03,
- Diagnosis & Treatment Sheet dates 4/3/03-4/17/03,
- Employees Notice of Injury of Occupational Injury,
- TWCC 73 dates ____-4/3/03,
- Clinical Worksheet Occupational Medicine dates 3/24/03-3/28/03,
- Patient Report dated 3/23/03 from _____,
- Med-Alert Progress Notes dates _____,
- Musculoskeletal Examination dated _____.

Submitted by Respondent:

- Correspondence Letter dated 8/17/04 from _____
- Medical Dispute Resolution Request/Response
- Table of Disputed Services dates 8/7/03-12/18/04
- Peer Review dated 6/23/03 from _____

Clinical History

I have had the opportunity to review the medical records in the above-mentioned case for the purpose of an Independent Review. The claimant is a 37-year-old female who injured her bilateral knees when she was involved in a motor vehicle accident on _____. She was apparently driving a school bus when she attempted to avoid a collision with another vehicle when the bus apparently struck a concrete wall. The claimant was seen initially for treatment from the _____ and was diagnosed with contusion to bilateral knees. The claimant sought treatment with multiple providers including _____, _____ and _____. The claimant continued to complain of right knee pain and a MRI of the right knee was performed on 4/9/03 at _____. The MRI of the right knee revealed intact ligamentous restraints of the knee, essentially unremarkable menisci, and subcutaneous soft tissue swelling anterior to the patella. The claimant consulted with _____ on 4/24/03 who recommended and performed an evacuation of the hematoma on the right knee before it changed to scar tissue. The claimant was referred to _____ for active therapy. The claimant had approximately 21 active and passive therapy visits for the right knee. The claimant then participated in a work hardening/work conditioning program at _____. The claimant had a required medical examination performed by _____ who determined the claimant at MMI and also recommended the claimant could return to work.

Requested Service(s)

(97545 WH-CA) work-hardening initial, (97546 WH-CA) work hardening each additional hour, (97750-FC) functional capacity evaluation for dates of service 8/7/03-12/18/03.

Decision

I agree with the insurance carrier that (97545 WH-CA) work hardening initial, (97546 WH-CA) additional hour of work-hardening and (97750-FC) functional capacity evaluation are not reasonable and necessary.

Rationale/Basis for Decision

The claimant apparently suffered a contusion to her bilateral knees as evident per the MRI finding on 4/9/03. The claimant had the hematoma of the right knee evacuated by _____ and participated in approximately 21 active and passive therapy sessions with _____. This treatment alone exceeds the recommendation of the Official Disability Guidelines, which does not recommend that any active rehabilitation is needed for an apparent contusion to the knee. Therefore the above disputed services are not medically reasonable and necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of September 2004.