

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

SOAH DOCKET NO. 453-05-2774.M5

MDR Tracking Number: M5-04-4174-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 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 (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 August 9, 2004.

The IRO reviewed work hardening program (97545 & 97546) and the Functional Capacity Evaluation (97750) for dates of service 03/23/04 through 05/28/04 that were denied based upon "V".

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The IRO upheld the insurance carrier denial and deemed the work hardening program and functional capacity evaluation **as not** medically necessary. The respondent raised no other reasons for denying reimbursement the work hardening program.

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.

On September 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.

- CPT Code 97750-FC for date of service 02/24/04. Neither party submitted an EOB. Per Rule 133.307(e)(2)(A) the HCFA-1500 was not submitted and it cannot be determined if services were rendered as billed. Reimbursement is not recommended.
- CPT Code 97545-WH-CA (2 hrs.) for date of service 05/04/04. Neither party submitted an EOB. Therefore, this code will be reviewed according to Rule 134.202. Per Rule 134.202(e)(5)(A) (i) & (e)(5)(C) work hardening notes support services were rendered as billed. Reimbursement in the amount of \$128.00 (\$64.00 x 2) is recommended.
- CPT Code 97546-WH-CA (4.25 hrs.) for date of service 05/04/04. Neither party submitted an EOB. Therefore, this code will be reviewed according to Rule 134.202. Per Rule 134.202(e)(5)(A) (i) & (e)(5)(C) work hardening notes support services were rendered as billed. Reimbursement in the amount of \$272.00 (\$64.00 x 4.25) is recommended.
- CPT Code 97750-FC (1.75 hrs.) for date of service 05/04/04. Neither party submitted an EOB. Therefore, this code will be reviewed according to Rule 134.202. Per Rule 134.202(e)(4) FCE report support services were rendered as billed. Reimbursement in the amount of \$100.00 is recommended.

On this basis, and 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 dates of service 05/04/04 through 05/04/04 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 15th day of October 2004

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 6, 2004

RE:

MDR Tracking #: M5-04-4174-01

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 an orthopedic reviewer who is board certified in orthopedic surgery and 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:

- Initial functional capacity evaluation dated 2/24/04 by ___.
- Intermediate functional capacity evaluation dated 4/23/04 by ___.
- Final functional capacity evaluation dated 5/4/04 by ___.
- Work hardening clinical documentation from 2/24/04 to 5/4/04 by ___.
- ___ report dated 3/25/04 by __, chiropractor.
- Letter of medical necessity by ___ of ___.

Submitted by Respondent:

- Claim documents of ____.
- Claim documents of ____.

Clinical History

The claimant sustained an alleged work compensable injury while employed with ____ on or about ____.

The nature of the injury was a repetitive use injury (RUI) that allegedly occurred after handling multiple packages at work. The claimant completed 25 sessions of physical therapy between 1/13/04 and 3/12/04.

Requested Service(s)

Initial Work Hardening (97545), work hardening each additional hour (97546), Functional Capacity Evaluation (97750). Dates of services in dispute: 3/23/04 through 5/28/04.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

Generally functional capacity evaluations and work hardening are indicated following documentation of objective evidence of a significant clinical condition that would preclude the usual transitional return to work with job accommodations and ergonomic assessment. The claimant's diagnoses include non-specific self limited sprain/strain of thoracic and lumbar spine. There is no documentation of abnormal neurologic exam. There is no objective documentation in the form of EMG nerve conduction studies, x-rays or MRI. The claimant successfully completed 25 sessions of physical therapy. The claimant could perform repetitive lifting activities at a medium level capacity after completing physical therapy. There is no clearly documented clinical rationale explaining why a well structured home exercise program, bracing, in concert with usual and customary return to work accommodations and ergonomic assessment would be any less effective than the work hardening and functional capacity evaluations that were performed between 3/23/04 and 5/28/04.