

MDR Tracking Number: M5-04-4314-01

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, 133.307 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 06-21-04.

The IRO reviewed work hardening rendered from 10-01-03 through 11-12-03 that was denied based upon "V".

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.

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

On 06-28-04, 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.

CPT code 97545-WH-CA dates of service 10-07-03, 10-08-03, 10-09-03, 10-10-03, 10-20-03, 10-21-03, 10-22-03 and 10-23-03 (8 DOS) (8 units of the initial two hours) denied with denial code "R" (extent of injury). The issue of extent was resolved via a Benefit Review Conference held on 04-28-04 in favor of the claimant. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$128.00 (initial 2 hours) x 8 units for a total reimbursement of \$1,024.00.

CPT code 97546-WH-CA dates of service 10-07-03, 10-08-03, 10-09-03, 10-10-03 and 10-23-03 (15 units), date of service 10-20-03 (3.25 units), dates of service 10-21-03 (2.75 units) and 10-22-03 (2.75 units) denied with denial code "R" (extent of injury). The issue of extent was resolved via a Benefit Review Conference held on 04-28-04 in favor of the claimant. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$1,520.00 (\$64.00 X 23.75 units).

CPT code 97750-FC date of service 11-12-03 (5 units) denied with denial code "R" (extent of injury). The issue of extent was resolved via a Benefit Review Conference held on 04-28-04 in favor of the claimant. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$184.70 (\$29.55 X 125% = \$36.94 X 5 units).

This Findings and Decision is hereby issued this 22nd day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

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 effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-07-03, 10-08-03, 10-09-03, 10-10-03, 10-20-03, 10-21-03, 10-22-03, 10-23-03 and 11-12-03 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 22nd day of December 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION

November 11, 2004

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

RE: Injured Worker:
MDR Tracking #: M5-04-4314-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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. TMF'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 TMF 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 45 year-old female injured her back and neck on ___ while lifting luggage on and off the shuttle bus she drove. She has been treated with therapy and medication

Requested Service(s)

Work hardening program for dates of service 10/01/03 through 11/12/03

Decision

It is determined that there is no medical necessity for the work hardening program for dates of service 10/01/03 through 11/12/03 to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity of a work hardening program. Therapeutic exercise may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. Although reference to a concurrent home program was made in the functional capacity reports, there was no documentation of it's specifics in the medical record, nor was there a basis provided supporting the medical necessity of these services requiring one-on-one supervision. With no evidence to support the need for monitored therapy, services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services. Therefore, the work hardening program for dates of service 10/01/03 through 11/12/03 was not medically necessary for the treatment of the patient's medical condition.

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-04-4314-01

Information Submitted by Requestor:

- Requestor's Position
- Work Hardening Program
- Dr. Funderburk's Review

Information Submitted by Respondent:

- Respondent's Position
- Dr. Funderburk's Review
- Independent Review