

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:  
SOAH DOCKET NO. 453-05-4457.M5**

MDR Tracking Number: M5-05-1185-01

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 12-17-04.

The IRO reviewed work hardening, work hardening each additional hour and functional capacity evaluation rendered from 04-13-04 through 05-12-04 that were 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.

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 01-05-05, 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.

Review of CPT codes 97545-WH-CA and 97546-WH-CA (4 units) date of service 04-21-04 revealed that neither party submitted EOBS. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of requestor receipt of providers request for EOBS. Per Rule 133.307(e)(3)(B) the respondent did not submit EOBS as required. Reimbursement is recommended per the Medicare Fee Schedule effective 08-01-03 in the amount of \$256.00 (\$64.00 X 4 units).

**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 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 date of service 04-21-04 in this dispute.

This Findings and Decision and Order are hereby issued this 26<sup>th</sup> day of January 2005.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division  
DLH/dlh



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** January 25, 2005

**To The Attention Of:**

TWCC  
7551 Metro Center Drive, Suite 100, MS-48  
Austin TX 78744-16091

**RE: Injured Worker:**

**MDR Tracking #:** M5-05-1185-01

**IRO Certificate #:** 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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:**

- MDR request letter
- MRI reports
- NCV/EMG reports
- HCFA-1500's
- Denial letters
- Daily notes
- Work hardening notes

- Psychological notes
- FCE reports
- Impairment ratings

### **Submitted by Respondent:**

- Brief letter from the carrier
- MRI reports
- NCV/EMG reports
- Peer review
- Designated doctor report
- Letter from the carrier reporting no impairment

### **Clinical History**

According to the supplied documentation, it appears the claimant sustained an injury on \_\_\_\_ when the claimant injured his wrist while performing repetitive sandblasting. On or about that date the claimant reported to a chiropractor who began chiropractic/physical therapy. On 2/26/04, the claimant changed treating physicians to an accident and injury doctor. The claimant's chiropractic therapy continued. On 3/10/04, the claimant underwent an NCV/EMG which revealed a negative NCV and a delay in the C7 responses and in left somatosensory response, findings which raise a possibility of bilateral C6 and left C7-T1 radiculopathy. On 3/12/04, the claimant underwent an MRI to the right wrist which revealed no abnormalities. On 3/22/04, the claimant underwent an MRI to the right hand which revealed no abnormalities. FCE's were performed which revealed inability to perform his normal activities at work. The claimant underwent a work hardening program. On 6/10/04, an impairment rating was performed by a doctor selected by the treating doctor which revealed a 6% whole person impairment. On 6/18/04, a designated doctor performed an impairment rating and assigned the claimant a whole person impairment of 0%. The documentation ends here.

### **Requested Service(s)**

97545-WH-CA work hardening, 97546-WH-CA work hardening each additional hour and 97750-FC functional capacity evaluation for dates of service 4/13/04, 4/14/04, 4/16/04, 4/19/04, 4/20/04, 4/22/04, 4/23/04, 4/26/04, 4/27/04, 4/28/04, 4/29/04, 4/30/04, 5/3/04, 5/4/04, 5/10/04, 5/11/04, 5/12/04.

### **Decision**

I agree with the insurance carrier that the services were not medically necessary.

### **Rationale/Basis for Decision**

According to the supplied documentation, it appears the claimant sustained an injury on \_\_\_\_ to his right wrist. Objective documentation including MRI reports and NCV/EMG reports limits the injury to a sprain/strain and do not clinically support any diagnosis greater than that of a

sprain/strain of the wrist. The deficiencies reported in the FCE were not objectively supported diagnostically in the documentation supplied. The amount of therapy performed on the claimant prior to the work hardening program would be an adequate amount of therapy in order to reduce the claimant's symptoms in order to return him to his normal activities of daily living. The documentation supplied, as well as the letter from the treating doctor did not support the work hardening program for the compensable injury. If the claimant had any injuries greater than that of a sprain/strain, they would have been revealed on one of the MRI reports or on the NCV/EMG report. None of the therapy in question appears reasonable or medically necessary to treat the compensable injury dated \_\_\_\_.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 25<sup>th</sup> day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder