

Amended MDR Tracking Number: M5-05-1546-01 (**Previously M5-04-4142-01**)

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 133.307 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 08-05-04.

This AMENDED FINDINGS AND DECISION supersedes all previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 12-28-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 01-28-05. An Order was rendered in favor of the Requestor. The Requestor and Respondent appealed the Order to an Administrative Hearing because proper reimbursement for CPT code 99455-WP-V3 needs to be determined, DOS reviewed by IRO that were determined to be not medically necessary should read 12-19-03 and a service for review by IRO should have been listed as work hardening not work hardening/conditioning.

The IRO reviewed therapeutic procedure, work hardening initial and work hardening each additional hour rendered from 11-14-03 through 12-19-03 that were denied based upon "V".

The IRO determined that there **was** medical necessity for the therapeutic procedures for dates of service 11-14-03 through 11-19-04. The IRO determined that the work hardening initial and work hardening each additional hour for dates of service 11-24-03 through 12-19-03 **were not** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of 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 11-05-04, 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 99455-WP-V3 date of service 01-08-04 denied with denial code "V" (unnecessary treatment with peer review). Per Rule 129.5 this is a required report and is not subject to an IRO review. Reimbursement is recommended in the amount of \$195.00 per Rule 134.202(e)(6)(B).

AMENDED DECISION & 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 11-14-03, 11-17-03, 11-19-03 and 01-08-04 in this dispute.

This Amended Findings and Decision and Order are hereby issued this 8th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

October 26, 2004

Amended Letter 02/03/05

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 #: M5-04-4142-01
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 care. 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 28 year-old male injured his back, neck and right shoulder on ___ when he was lifting an extension ladder over his head and lost his balance causing him to bend backwards. He has been treated with therapy and medications.

Requested Service(s)

97110-therapeutic procedure for dates of service 11/14/03 through 11/19/03 and 97545-work hardening initial, 97546-work hardening each additional hour, for dates of service 11/24/03 through 12/19/03

Decision

It is determined that there is necessity for the therapeutic procedure for dates of service 11/14/03 through 11/19/04. However, the work hardening initial and work hardening each additional hour for dates of service 11/24/03 through 12/19/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates minimal restriction of range of motion. The Milgrams test was positive and Ely's elicits localized low back pain without neurological compromise. The mechanism of injury and his clinical presentation led to the diagnosis of lumbar strain/sprain for which the therapeutic procedures were medically necessary. Therefore, the work hardening initial and work hardening each additional hour for dates of service 11/24/03 through 12/19/03 was not medically necessary to treat this patient's medical condition. However, the therapeutic procedure from 11/14/03 through 11/19/03 was medically necessary to treat this 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 #: M5-04-4142-01

Information Submitted by Requestor:

- Functional Capacity Evaluation
- Work Hardening Program
- Progress Notes
- Diagnosis Tests
- Claims

Information Submitted by Respondent:

- Carrier's Position
- Peer Review