MDR Tracking Number: M5-03-0188-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the Commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

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. There are still fee issues to be resolved.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
9/10/01 9/11/01 9/12/01 9/13/01 9/14/01	97545WH (2 hrs) 97546WH (5 hrs)	$128.00x5 $320.00x5	0.00	N	$64.00/hr minus 20% for Non CARF ($51.20/hr)	96 MFG Med GR II C, E	"N - …documented services do not meet minimum fee guideline and/or the rules contained with the applicable AMA CPT/HCPCS coding guidelines." Work Hardening Weekly Summation Progress report for 9/10/01-9/14/01 states patient participated in a work hardening program for 7 hrs each day of this week; however, daily notes and daily activity chart do not support the total hours billed. Note for 9/11/01 supports aquatic therapy for 1 hr 25 min; 45 min of aerobics, and 20 min cool down aquatic class (total 2 hrs 20 min). Daily activity chart supports 1 hr 40 min of endurance activities for each day of the week for a total of 4 hrs. Group session documented; however no time given.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							Recommend reimbursement of $51.20 x 4 = $204.80. Note for 9/12/01 supports 1 hr aquatic therapy and daily activity chart supports 1 hr 40 min of endurance activities. Work hardening requires a minimum of 4 hrs and only 3 hrs were documented. No reimbursement recommended. Note for 9/13/01 supports 1 hr 30 min aquatic therapy and 1 hr 40 min of endurance activities. Work hardening requires a minimum of 4 hrs and only 3 hrs 10 min were documented. No reimbursement recommended. Note for 9/14/01 does not support actual timed activities and daily activity chart supports 1 hr 40 min of endurance activities. Work hardening requires a minimum of 4 hours and only 1 hr 40 min were documented. No reimbursement recommended.
9/17/01 9/18/01 9/19/01 9/20/01 9/21/01	97545WH (2 hrs) 97546WH (5 hrs)	$128.00 x 5 $320.00 x 5	0.00	N	$64.00/hr minus 20% for Non CARF ($51.20/hr)	96 MFG Med GR II C, E	Note for 9/17/01 supports 1 hr aquatic therapy and daily activity chart supports 1 hr 40 min of endurance activities. Work hardening requires a minimum of 4 hrs and only 2 hrs 40 min were documented. No reimbursement recommended. Note for 9/18/01 does not support actual timed activities and daily activity chart supports 1 hr 40 min of endurance activities. Work hardening requires a minimum of 4 hours and only 1 hr 40 min were documented. No reimbursement recommended. Notes for 9/19/01, 9/20/01, and 9/21/01 do not support

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
							actual timed activities and daily activity chart supports 1 hr 40 min of endurance activities for each of these dates. Work hardening requires a minimum of 4 hours and only 1 hr 40 min per day were documented. No reimbursement recommended.
9/10/01 9/11/01 9/12/01 9/13/01 9/14/01 9/17/01 9/18/01 9/19/01 9/20/01 9/21/01	99070	$ 15.00 x 10 = $150.00	0.00	N	DOP	96 MFG G. I. GR IV	Documentation supports 4.0 oz arctic ice applied to right knee to help decrease pain and swelling for all disputed dates of service except 9-10-01 and 9-14-01. Recommend reimbursement of $15.00 x 8 = $120.00.
9/11/01 9/17/01	E1399	$ 32.00 $ 32.00	0.00	N	DOP	96 MFG DME GR X	Documentation supports supply of TENS pad for use in EMS tens unit on 9-11-01 only. Recommend reimbursement of $32.00.
9/24/01 9/25/01 9/26/01 9/27/01 9/28/01 10/1/01 10/2/01 10/3/01 10/4/01 10/5/01 10/8/01 10/9/01 10/10/01 10/11/01 10/12/01	97545WH (2 hrs) 97546WH (5 hrs)	$128.00 x 15 $320.00 x 15	0.00	V	$64.00/hr minus 20% for Non CARF ($51.20/hr)	IRO Decision	The IRO determined these services were medically necessary. Recommend reimbursement of $128.00 x 20% = $102.40 x 15 = $1,536.00 $320.00 x 20% = $256.00 x 15 = $3,840.00 = $5,376.00
9/24/01 9/25/01 9/26/01 9/27/01 9/28/01 10/1/01 10/2/01 10/3/01 10/4/01 10/5/01	99070	$ 15.00 x 15 = $225.00	0.00	V	DOP	IRO Decision	The IRO determined these services were medically necessary. Recommend reimbursement of $ 15.00 x 15 = $225.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
10/8/01 10/9/01 10/10/01 10/11/01 10/12/01							
9/25/01 10/2/01 10/9/01	E1399	$ 32.00 x 3 = $ 96.00	0.00	N	DOP	96 MFG DME GR X	The IRO determined these services were medically necessary. Recommend reimbursement of $ 32.00 x 3 = $ 96.00.
TOTAL		$11735.00	0.00				The requestor is entitled to reimbursement of $6,053.80

Consequently, the Commission has determined that **the requestor prevailed** on the majority of the medical fees ($6,380.00). Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor** $460.00 for the paid IRO fee.

The above Findings and Decision are hereby rendered this 21st day of March 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay $6,380.00 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 9/10/01 through 10/12/01 in this dispute.

This Order is hereby issued this 21st day of March 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

December 5, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0188-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent

review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on ___ external review panel. ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 37 year-old female who sustained a work related injury to her right knee on ___. The diagnosis of the injury is a full thickness tear of the ACL with moderate effusion, multilane lateral meniscal tear, and synovitis of the patellofemoral joint- medial and lateral compartment. The patient had an MRI. Treatment has included Arthroscopy, partial lateral meniscectomy, and synovectomy of the patellofemoral joint – medial and lateral compartment. She has also participated in rehabilitation and work hardening.

Requested Services

Work hardening, supplies and durable medical equipment on 9/24/01 through 10/12/01.

Decision

The Carrier's denial of coverage for these services is overturned.

Rationale/Basis for Decision

___ chiropractor reviewer has determined that based on the records provided the work hardening, supplies and durable equipment from 9/24/01 through 10/12/01 were medically and clinically necessary. ___ chiropractor reviewer further determined that the post-operative cane was also appropriate. Therefore, ___ chiropractor consultant has concluded that the requested services are medically necessary for treatment of the patient's condition.

Sincerely,

___