

MDR Tracking Number: M5-03-1707-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 3-25-03.

The IRO reviewed work hardening program rendered from 8-1-02 through 8-23-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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

On July 9, 2003, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

Neither party submitted EOBs to support services identified as "No EOB"; therefore, they will be reviewed in accordance with *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-17-02 8-15-02 8-21-02	97545WHAP (2 hours)	\$128.00	\$0.00	No EOB	\$64.00 /hr	Medicine GR (II)(E)	Work hardening report supports billed service per MFG, reimbursement of 3 dates X \$128.00 = \$384.00.
7-17-02	97546WHAP	\$256.00	\$0.00	No	\$64.00 /hr	Medicine GR	Work hardening report

8-15-02 8-21-02	(4 hours)			EOB		(II)(E)	supports billed service per MFG, reimbursement of 3 dates X \$256.00 = \$768.00.
8-22-02	97750FC	\$200.00	\$0.00	F	\$100.00/hr	Medicine GR (I)(E)(2)(a)	FCE report supports billed service per MFG, reimbursement of \$200.00 is recommended.
8-14-02	97545WHAP (2 hours)	\$128.00	\$0.00	D	\$64.00 /hr	Medicine GR (II)(E)	Work hardening was not a duplicate service provided on this date. Work hardening report supports billed service per MFG, reimbursement of \$128.00 is recommended.
8-14-02	97546WHAP (4 hours)	\$256.00	\$0.00	D	\$64.00 /hr	Medicine GR (II)(E)	Work hardening was not a duplicate service provided on this date. Work hardening report supports billed service per MFG, reimbursement of \$256.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of <b>\$1736.00.</b>

This Decision is hereby issued this 31<sup>st</sup> day of December 2003.

Elizabeth Pickle  
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 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 Decision is applicable for dates of service 7-17-02 through 8-15-02 in this dispute.

This Order is hereby issued this 31<sup>st</sup> day of December 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

June 30, 2003

Re: Medical Dispute Resolution  
MDR #: M5-03-1707-01  
IRO Certificate No.: 5055

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:

This male claimant was injured on his job on \_\_\_\_. He injured his mid and low back, complaining of stabbing and shooting pain in that area.

The patient was evaluated with a FCE, which indicated that he was not capable of returning to his usual employment. He was placed through a work hardening program, at the end of which the exit FCE showed improvement. The patient was determined to be fit to return to usual employment.

Disputed Services:

Work hardening program from 08/02/02 through 08/23/02.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the work hardening program was medically necessary in this case.

Rationale for Decision:

This patient had the appropriate indications for work hardening. He participated in a compliant fashion and benefited from this program. The medical necessity was present, and the program achieved its results.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,