

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, titled Medical Dispute Resolution of a Medical Fee Dispute, a dispute resolution review was conducted by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above. This dispute was received on 1-25-02.

This AMENDED FINDINGS AND DECISION supersedes M5-02-2123-01 previous Decisions rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division’s Decision of was appealed and subsequently remanded by the State Office of Administrative Hearing to the Medical Review Division because there was a discrepancy between the decision of the IRO and the MRD hearing officer...the IRO found that medical necessity had been established.”

I. DISPUTE

Whether there should be reimbursement for work hardening program.

II. FINDINGS & RATIONALE

The IRO reviewed work hardening program rendered from 1-15-01 through 2-23-01 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 \$460.00** 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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-15-01 1-16-01 1-18-01 1-19-01 1-22-01 1-23-01 1-24-01 1-25-01 1-26-01 1-29-01 1-31-01 2-1-01	97545WH	\$128.00	\$0.00	U	\$51.20/hr for Non-CARF X 2 hrs.= \$102.40	Medicine GR (II)(C) and (E)	IRO found medically necessary, reimbursement of \$102.40 X 28 dates = \$2867.20.

2-2-01 2-5-01 2-6-01 2-7-01 2-8-01 2-9-01 2-12-01 2-13-01 2-14-01 2-15-01 2-16-01 2-19-01 2-20-01 2-21-01 2-22-01 2-23-01							
1-15-01 1-16-01 1-18-01 1-19-01 1-22-01 1-23-01 1-24-01 1-25-01 1-26-01	97546WH (5)	\$320.00	\$0.00	U	\$51.20/hr for Non-CARF X 5 hrs. = \$256.00	Medicine GR (II)(C) and (E)	IRO found medically necessary, reimbursement of \$256.00 X 9 dates = \$2304.00.
1-29-01 1-31-01 2-1-01 2-2-01 2-5-01 2-6-01 2-7-01 2-8-01 2-9-01 2-12-01 2-13-01 2-14-01 2-15-01 2-16-01 2-19-01 2-22-01 2-23-01	97546WH (5)	\$352.00	\$0.00	U	\$51.20/hr for Non-CARF X 5 hrs. = \$256.00	Medicine GR (II)(C) and (E)	IRO found medically necessary, reimbursement of \$256.00 X 17 dates = \$4352.00
2-20-01 2-21-01	97546WH (2)	\$128.00	\$0.00	U	\$51.20/hr for Non-CARF X 2 hrs. = \$102.40	Medicine GR (II)(C) and (E)	IRO found medically necessary, reimbursement of \$102.40 X 2 dates = \$204.80
TOTAL							The requestor is entitled to reimbursement of \$9728.00.

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

III. 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 (\$9728.00 + \$460.00) \$10,188.00 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 1-15-01 through 2-23-01 in this dispute

The above Amended Findings and Decision are hereby issued this 27th day of October 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division

April 18, 2002

Texas Workers' Compensation Commission
David R. Martinez, Chief
Medical Dispute Resolution
4000 South IH-35, MS 40
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5-02-2123-01
IRO Certificate No.: IRO 5055

Dear:

___ 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 practitioner of Chiropractic Medicine.

THE REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning Case #M5-02-2123-01, in the area of Chiropractic Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for Medical Dispute Resolution and reimbursement for a work hardening program.
2. Carrier's denial and stated reasons for denial.
3. Doctor's explanation of necessity of work hardening program.
4. HCFA-1500's.
5. Weekly reports from doctor's office.
6. Impairment rating, correspondence, and designated doctor's report.
7. FCE/March 21, 2000.
8. FCE/January 2, 2001.
9. Pre-program medical records.

B. SUMMARY OF EVENTS:

The patient sustained a work-related injury on _____, while working as a cook/food-prep, carrying a 70-pound bucket of carrots. The pain onset was immediate in the low lumbar region.

The patient has since seen numerous specialists, and various diagnostic studies have confirmed the diagnosis of a lumbar disk radiculopathy. A series of injections was performed with no true symptomatic benefit.

Some of the specialists suggest that greater invasive applications such as a neurostimulator and morphine pump are appropriate for pain management.

However, nearly all of the multi-disciplinary specialists in this case make references for the need for further physical therapy and ongoing medical care except _____, who states, "His opinion could be changed with additional information."

The designated doctor, _____ states that ongoing treatment is relevant even after the MMI date of 01/30/01 if the treating doctor feels that it is appropriate and if its application is determined by subjective and objective means of analysis.

C. OPINION:

1. I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE ABOUT THE ISSUE OF MEDICAL NECESSITY AND, THUS, THE ISSUE OF NON-PAYMENT FOR SERVICES RENDERED.
2. It is the opinion of this reviewer that ___ utilized objective means (FCE - 01/02/01) to render the decision to enroll the patient into a work hardening program. Further, it is evident that the rationale stated by the review agent is not applicable to this case because medical necessity is outlined by the designated doctor in his report when he states that further treatment will be appropriate if there is an objective means to determine its application. In this case, the FCE - 01/02/01 provides this data.
3. Screening criteria utilized takes reference with extracted rehabilitation protocols of the American Chiropractic Rehabilitation Board, strengthening guidelines set forth by the National Strength and Conditioning Association, referral data present in these records, and practice experience.
4. The work hardening services rendered by ___ were medically appropriate for work hardening reimbursement and medically necessary, per the data reviewed.

D. ADDITIONAL COMMENTS:

___ has not shown CARF affiliation in any of the documentation that I have reviewed.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 16 April 2002