

MDR Tracking Number: M5-02-2368-01

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 is still an unresolved fee dispute.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
8/6/01	97545WH 97546WH	\$128.00 \$256.00	0.00	V	\$64.00/hr minus 20% if non-CARF	IRO decision	The IRO determined that the work hardening program was not medically necessary. Therefore no reimbursement is recommended.
8/7/01	97545WH 97546WH	\$128.00 \$256.00	0.00	V			
8/8/01	97545WH 97546WH	\$128.00 \$256.00	0.00	V			
8/9/01	97545WH 97546WH	\$128.00 \$256.00	0.00	V			
8/10/01	97545WH 97546WH	\$128.00 \$256.00	0.00	V			
9/10/01	97545WH 97546WH	\$128.00 \$256.00	0.00	No EOB			
9/11/01	97545WH 97546WH	\$128.00 \$256.00	0.00	No EOB			
9/12/01	97545WH 97546WH	\$128.00 \$256.00	0.00	No EOB			
TOTAL		\$3,072.00					The requestor is not entitled to reimbursement.

The above Findings and Decision is hereby issued this 7th day of March 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 7, 2002

Re: IRO Case # M5-02-2368

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas and who also is a Certified Strength and Conditioning Specialist. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient was injured in ___ while making air filters. She presented to a chiropractor who diagnosed her with Carpal Tunnel Syndrome, myofascial disorder and cervical spine sprain. She was treated with chiropractic care and a work hardening program.

Requested Service

Work hardening program 8/6/01-9/12/01, except for DOS certified previously.

Decision

I agree with the carrier's decision to deny the disputed dates of service.

Rationale

The documentation presented does not show that chiropractic treatment gave the patient any relief of her symptoms. The patient was treated for bilateral CT syndrome, yet nerve conduction studies were negative for medial and ulnar nerve involvement.

The documentation presented shows that the patient made satisfactory progress early in the work hardening program. The program and its frequency were extensive. The patient reported satisfactory improvement shortly after starting the program, yet the frequency of rehab treatment continued. On 7/11/01 the patient reported feeling "a lot better" yet the work hardening program continued for two more months. On 8/3/01 the patient reported that her shoulder pain "is considerably improved." At that time, she should have been put on a strength and conditioning program to be done at home, and treatment after 8/3/01 was unnecessary. The documentation does not support the beneficial need to continue such an extensive program after 8/3/01. The patient should have been instructed on a home based strength and conditioning program consisting of stretching and resistive band training.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,