

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-1759.M5

MDR Tracking Number: M5-02-2476-01

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 and determined that **the requestor prevailed** on the issues of medical necessity. 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.

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 the only issue** to be resolved. The work hardening program, office visits and reports, FCE, range of motion, and muscle testing were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

The above Findings and Decision are hereby issued this 24th day of September 2002.

Dee Z. Torres, Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 4-3-01 through 8-27-01 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order per Rule 133.307(j)(2).

This Order is hereby issued this 24th day of September 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dzt

September 12, 2002

Texas Workers' Compensation Commission
Attention: Rosalinda Lopez
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5.02.2476.01
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 Doctor of Chiropractic Medicine.

The physician reviewer of this case **DISAGREES with the determination made by the insurance carrier. The reviewer is of the opinion that Office Visits on 4/3, 4/9, 4/11, 4/13, 4/16, 4/18, 4/20, 4/27, 5/4, 5/15, 6/1, 6/19, 6/21, 6/26, 7/5/01; Work Hardening on 4/23-25/01, 4/27, 4/30, 5/1-4/01, 5/10-11/01, 5/14-18/01, 5/21-25/01, 5/29-31/01, 6/1, 6/4, 6/5/01; Therapy Modalities on 4/3, 4/9, 4/11, 4/13, 4/16, 4/18, 4/20/01; Range of Motion 4/9/01, 4/11, 4/13, 4/16, 4/18, 4/20.01; Muscle Testing 4/16 FCE 5/16/01, 6/04/01; All Reports 6/1, 6/4, 6/18, 8/27/01 were medically necessary.**

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 _____. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2476-01, in the area of Chiropractic and Work Hardening. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request/Response.
2. Table of Disputed Services.
3. EOB, denial of services from insurance carrier, 91 pages.
4. Reports dated 3/20/02, 5/30/01, and 1/15/02 from _____.
5. Peer review report from _____, dated 4/04/01.
6. Office visit and treatment notes from _____, 4/03/01 through 7/05/01, total of 20 pages.
7. Work hardening SOAP notes from _____ from _____, dates of services 4/23/01 through 6/05/01, total of 44 pages.
8. Progress notes from _____, _____, dated 5/01/01, 5/11/01, 5/18/01, and 6/05/01, total of 4 pages.
9. Functional Capacity Evaluation/Range of Motion Evaluation/Ergos Evaluation, total of 108 pages.

B. BRIEF CLINICAL HISTORY:

The records indicate the patient was injured on the job on _____, when he fell off an 8-ft. high scaffold and landed on the side, and the scaffold fell on him. The patient was treated by _____ and referred for a work hardening program. After the completion of such program, he was returned to work and was released from care and placed on a p.r.n. status.

C. DISPUTED SERVICES:

Dates of service 4/03, 4/09, 4/11, 4/13, 4/16, 4/18, and 4/20/01. Office visit charges, therapy modalities. Work hardening program from 4/23/01 through 6/05/01. TWCC Form #73, as required, dated 4/03/01, 6/04/01,

6/18/01, and 8/27/01. Range of motion testing 4/09/01. Muscle testing 4/16/01. Office visits (99213) on 4/27, 5/04, 5/15, 5/25, 6/01, 6/19, 6/26, and 7/05/01. FCE Evaluation dated 5/16/01 and 6/04/01.

D. DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE REGARDING THE FOLLOWING POINTS:

1. All of work hardening program.
2. Office visits (99213) dated 4/27, 5/04, 5/15, 5/25, 6/01, 6/19, 6/26, and 7/05/01.
3. Range of motion testing on 4/09/01 and muscle testing on 4/16/01.
4. All reports which are required and are compensable.
5. FCE dated 5/16/01 and 6/04/01.
6. Office visits (99213) dated 4/03, 4/09, 4/11, 4/13, 4/16, 4/18, and 4/20/01.

The area that remains in dispute would be the therapy modalities and procedures which were performed and listed in the Table of Disputed Services on 4/03, 4/09, 4/11, 4/13, 4/16, 4/18, and 4/20/01. The records I have indicate the patient was first seen on February 1, 2001, by _____. No specific records are enclosed to confirm when the initial eight weeks of treatment began for this injury. I assume these services were within the initial eight-week period of time and they would be medically necessary.

E. RATIONALE OR BASIS FOR DECISION:

The records indicate this patient was treated for an on-the-job injury which he sustained. Throughout the course of treatment, he received office visits, myofascial release, joint mobilization, therapeutic exercises, additional diagnostic testing, and FCE. The results of these tests indicated the patient was a candidate for a work hardening program, which was needed in order for the patient to recover from said injury and return to his normal occupation.

I have reviewed the records and the peer review report, and it appears to me that this doctor did not have the results of the initial FCE and possibly other documentation or he did not take into consideration these reports when making the determination. Given the nature and the extent of this patient's injury and the traumatic nature of such, and given the fact the FCE revealed significant problems, it was, in fact, medically necessary for this patient to receive the care he received and begin a work hardening program. As the patient progressed through the work hardening program,

additional FCE's were performed, which documented and measured his improvement. Once the patient had completed the work hardening program, he was released to return to work and released from care to a p.r.n. basis.

It is my opinion, therefore, that the treatment rendered in this case was, in fact, medically necessary and reasonable for this patient to recover from his on-the-job injury and return to work.

F. 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: 7 September 2002