

MDR Tracking Number: M5-02-2564-01

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 IRO reviewed work hardening program rendered from 10-2-01 to 11-9-01 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(q)(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.**

**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.

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

On May 23, 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:

Services denied without an EOB will be reviewed in accordance with *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
6-26-01 7-05-01 7-17-01 7-24-01 7-26-01 7-30-01 7-31-01 8-21-01 8-22-01 8-23-01 9-06-01 9-13-01	97261	\$10.00	\$0	N	\$8.00	CPT Code Descriptor	The 97260 CPT code descriptor states, "Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area. 97261 applies to each additional area. Medicine GR (I)(D)(1)(c), identifies the upper extremities as a body area. Therefore, the manipulation of both upper extremities applies to manipulation of one body area. Therefore, no reimbursement is due.
7-12-01	A4556	\$60.00	\$0	N	DOP	General Instructions GR (IV)	DOP is required for any single supply that is billed at \$50.00 or greater. DOP was not met. Reimbursement is not recommended.
TOTAL							The requestor is not entitled to reimbursement.

This Decision is hereby issued this 5<sup>th</sup> day of August 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 6-26-01 through 11-9-01 in this dispute.

This Order is hereby issued this 5<sup>th</sup> day of August 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

August 23, 2002

**REVISED LETTER**

Re: Medical Dispute Resolution  
MDR #: M5-02-2564-01  
IRO Certificate No.: IRO 5055

This letter is to correct a letter dated August 19, 2002 in which we are revising the dates contained in the third (3<sup>rd</sup>) paragraph, correcting the beginning date to 10.02.01 and adding the ending date of 11.09.01. This revised letter **IN NO WAY** changes the opinion of the reviewer.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Chiropractic Doctor.

THE REVIEWER OF THIS CASE **DISAGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE. **The reviewer has determined that the work hardening program on 10.02.01 through 11.09.01 WAS medically necessary in 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 TWCC Case File #M5-02-2564-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution request.
2. Explanation of Reimbursement by \_\_\_\_\_.
3. Job description for patient.
4. RME, 5/01/02, \_\_\_\_\_.
5. Pain management report, 3/20/02, \_\_\_\_\_.
6. Work hardening daily exercise notes, 10/02/01 to 11/09/01.
7. SOAP notes, \_\_\_\_\_, 8/21/01, to 9/13/01.
8. Operative report, left CTS, \_\_\_\_\_, 8/03/01.
9. Operative report, right CTS, \_\_\_\_\_, 5/14/01.
10. Neurologist's exam, \_\_\_\_\_, 10/30/01.
11. FCE, \_\_\_\_\_, 9/28/01.

B. BRIEF CLINICAL HISTORY:

The patient was a pallet repairer who was injured on \_\_\_\_\_, diagnosed with bilateral CTS. He had surgery, bilateral, without benefit. He was then diagnosed with complex regional pain disorder. He was then put into a work hardening and pain management program.

C. DISPUTED SERVICES:

1. Manipulation, 6/26/01 to 9/13/01.
2. TENS unit replacement pad, 7/12/01.
3. Work hardening, 10/2/01 to 11/09/01.

D. DECISION:

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

Manipulation to affected/injured area post-surgical is appropriate treatment to reduce development of post-surgical adhesions or scarring of tissues involved. Joint or soft tissue mobilization techniques are indicated concerning this patient's condition.

TENS unit has been prescribed and was accepted by the insurance company. It would be appropriate to recommend and provide the patient with replacement pads as appropriate.

The specific reason why this patient warrants and is a candidate for a work hardening program starts with his relevant clinical findings and his present physical ability to enter into and endure a work hardening program. \_\_\_\_, the treating doctor, presented a goal-oriented, individualized treatment program designed to maximize the ability of the patient to return to work. Functional, physical, behavioral, and vocational needs were met by \_\_\_\_ program. In my review, simulated work activities and physical conditioning tasks were presented.

The patient is likely to benefit from a work hardening program. His current levels of function due to his injury interfered with his ability to carry out specific tasks required in the workplace. His medical and physiological condition did not prohibit participation in the work hardening program. \_\_\_\_ also presented documentation from group therapy sessions, provided by a qualified mental health provider, as required in work hardening.

\_\_\_\_ utilized an FCE which demonstrated deficits which justified his goals in the work hardening program. The patient has not previously gone through a highly structured, supervised program previous to the recommendation of the work hardening program by \_\_\_\_\_. No contraindications were identified, and the patient was capable of performing the work hardening activities indicated which \_\_\_\_ exam information presented.

E. RATIONALE OR BASIS FOR DECISION:

Recommendation for work hardening was appropriate with screening criteria met by \_\_\_\_, per *Spinal Treatment Guidelines*. In review of the medical information provided, this patient's case meets all required criteria for entrance and participation in a work hardening program.

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: 13 August 2002