MDR Tracking Number: M5-02-3215-01

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 9-17-01 to 10-3-01 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of 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 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 February 11, 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:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
10-8-01 10-9-01 10-10-01 10-11-01	97545WH	$128.00 X 4 = $512.00	$64.00	F	$64.00/hr	Medicine GR (II)(E)	The requestor did not submit work hardening program reports to support billed service. Reimbursement is not recommended.
10-8-01	97546WH	$192.00	$153.00	F	$64.00/hr		
10-9-01 10-10-01 10-11-01	97546WH	$320.00 X 3 = $960.00	$256.00	F	$64.00/hr		
TOTAL		$1664.00					The requestor is not entitled to reimbursement.

This Decision is hereby issued this 14th day of July 2003.

Elizabeth Pickle
Medical Dispute Resolution OfficerMedical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 24, 2002

Requester/ Respondent Address: Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-02-3215-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractic physician reviewer. The chiropractic physician reviewer has signed a certification statement stating 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 the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant was trying to a get an envelope out of a machine when her right hand got caught in the machine causing an injury to her right wrist and neck. She went to the chiropractor who treated her for her sustained injuries. The claimant was diagnosed with cervical sprain/strain (847.0), contusion of eyelids and periocular area (921.1) and a headache (784.0). She was treated with chiropractic care then was referred for a work hardening program, which she completed on 10/12/2001.

Requested Service(s)

Please review and address the medical necessity of the work hardening services rendered 09/17/2002 – 10/03/2001

Decision

I agree with the insurance company that the work hardening program was not medically necessary.

Rationale/Basis for Decision

The patient was diagnosed with a headache, contusion of the eyelid or periocular area and a cervical sprain/ strain. According to the supplied documentation, the claimant did not have a positive MRI, nerve conduction velocity or any other diagnostic test that would have warranted the work hardening program. The patient was treated with conservative care and at that time could have been released with a home exercise program that could have help complete her care.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of December 2002.