

MDR Tracking Number: M5-04-0937-01

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, 133.307 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. This dispute was received on 12-01-03. Date of service 11-20-02 per Rule 133.308(e)(1) was not timely filed.

The IRO reviewed work hardening, office visits, chiropractic manipulations, electrical stimulation, vasopneumatic devices and neuromuscular re-education rendered from 12-04-02 through 10-08-03 that was denied based upon "V".

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.

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 02-05-04, 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\$	Reference	Rationale
12-11-02 and 12-18-02 (2 DOS)	99213	\$96.00 (1 unit @ \$48.00 X 2 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
6-23-03	97545	\$1,664.00	\$0.00	F, A X170	\$64.00	96 MFG	F, A X170 –

through 7-18-03 (13 DOS)	-WH-AP	(2 units @ \$128.00 X 13 DOS)			(per hr CARF provider)	MEDICINE GR(II)(C)	Denied for preauthorization. CARF providers do not require preauthorization, therefore reimbursement recommended in the amount of \$128.00 X 13 DOS = \$1,664.00
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
6-23-03 through 7-18-03 (13 DOS)	97546 -WH-AP	\$1,664.00 (2 units @ \$128.00 X 13 DOS)	\$0.00	F, A X170	\$64.00 (per hr CARF provider)	96 MFG MEDICINE GR (II)(C)	F, A X170– Denied for preauthorization. CARF providers do not require pre-authorization, therefore reimbursement recommended in the amount of \$128.00 X 13 DOS = \$1,664.
8-5-03 through 8-7-03 (3 DOS)	97545 -WH-AP	\$384.00 (2 units @ \$128.00 X 3 DOS)	\$0.00	F	\$64.00 (per hr CARF provider)	96 MFG MEDICINE GR (II)(C)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
8-5-03 through 8-7-03 (3 DOS)	97546 -WH-AP	\$384.00 (2 units @ \$128.00 X 3 DOS)	\$0.00	F	\$64.00 (per hr CARF provider)	96 MFG MEDICINE GR (II)(C)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
3-19-03 through 4-23-03 (3 DOS)	99213	\$144.00 (1 unit @ \$48.00 X 3 DOS)	\$0.00	D	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine reason for original denial. No reimbursement

							recommended.
4-30-03	99213	\$48.00 (1 unit)	\$0.00	F	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
1-30-03	97530	\$35.00 (1 unit)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine reason for original denial. No reimbursement recommended.
1-30-03	97112	\$35.00 (1 unit)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine reason for original denial. No reimbursement recommended.
1-30-03	97110	\$70.00 (2 units)	\$0.00	D	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine reason for original denial. No reimbursement recommended.
TOTAL		\$4,572.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$3,328.00

This Decision is hereby issued this 4th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

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 12-04-02 through 10-08-03 in this dispute.

This Order is hereby issued this 4th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

April 30, 2004

REVISED REPORT Corrected services in dispute.

MDR #: M5-04-0937-01
IRO Certificate No.: IRO 5055

___ 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.

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.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Information Provided for Review:

Correspondence
H&P and office notes
Physical Therapy notes
Radiology reports

Clinical History:

This patient injured his low back at work on _____. Treatment has included trigger point injections, active rehabilitative care, passive care, facet blocks, epidural steroid injections, bilateral L4-L5 discectomy, right L3-L4 discectomy, L3-L5 laminectomy, L4-L5 posterior lumbar interbody fusion, L3-L5 transforaminal interbody fusion using hardware and iliac bone graft. This patient experienced some complications post-surgically.

Disputed Services:

Work hardening, office visits, chiropractic manipulations, electrical stimulation, vaso-pneumatic devices, and neuromuscular re-education during the period of 12/04/02 through 10/08/03.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatments and services in disputed as stated above were medically necessary in this case.

Rationale:

The services provided aided the patient in reducing his chronic pain syndrome. The treatment provided to the patient was to relieve his symptomatology naturally resulting from the compensable injury. The services that are being disputed are reasonable given the patient's chronic pain condition. CARF Guidelines have an extensive discussion regarding the medical necessity and admission requirements of a work-hardening program. The initial examination revealed decreased physical demand capacity. That, by itself, is not the only factor in determining admission requirements for the work-hardening program. The rationale listed for placing this patient in a work-program included decreased PDC, poor endurance due to undocumented factors, decreased range of motion, and high-subjected pain index.

The tertiary phase of care is interdisciplinary, individualized, coordinated, and intensive. It is designed for the injured employee who demonstrates physical and psychological changes consistent with a chronic condition. Psychosocial issues such as substance abuse, affective disorders, and other psychological disorders may be present. There is documented inhibition of physical function evidenced by pain sensitivity and non-organic signs, such as fear, which produce a physical inhibition or limited response to reactivation treatment. This phase of care may also be indicated for the injured employee whose physical capacity to work still does not meet the current or expected job requirements after adequate treatment, thereby causing the inability to return to full duty. The situation would be evidenced by an excessive transition period of light duty or significant episodes of lost work due to a need for continued medical treatment. This phase of care is also indicated for those injured employees who cannot tolerate either initial or intermediate phases of care. This patient required the work hardening and relief care in the form of chiropractic manipulation, electrical stimulation, vaso-pneumatic devices, and neuromuscular reeducation.

According to the Texas Labor Codes Section 408.021, an employee who sustains a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to all healthcare that:

1. Carries a relief of the effects naturally resulting from the compensable injury,
2. Promotes recovery; or,
3. Enhances the ability of the employee to return to or obtain employment.