

Amended MDR Tracking Number: M5-04-1002-01 (**Previously M5-02-3049-01**)

This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

The Medical Review Division's Findings and Decision of August 12, 2003, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.

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, impairment rating exam and FCE rendered from 7-27-01 to 9-26-01 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 August 5, 2003, and September 3, 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
7-31-01 8-1-01 8-2-01 8-3-01	97545WH	\$128.00	\$0.00	A	\$64.00 / hr CARF accredited	Rule 134.600(h)(11) Rule 133.307(g)(3)(B)	The disputed work hardening was in the initial 6 weeks and did not require preauthoirzation. Therefore, the insurance carrier incorrectly denied reimbursement based upon "A".
7-31-01	97546WH	\$256.00	\$0.00	A	\$64.00 / hr CARF accredited		

8-1-01 8-3-01	97546WH	\$320.00	\$0.00	A	\$64.00 / hr CARF accredited		The requestor did not submit medical records in accordance with Rule 133.307(g)(3)(B) to support fee dispute.  Therefore, no reimbursement is recommended.
TOTAL							The requestor is not entitled to reimbursement .

This Decision is hereby issued this 15th day of December 2003.

Elizabeth Pickle  
Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

**IRO Certificate #4599**

### NOTICE OF INDEPENDENT REVIEW DECISION

November 25, 2002, Corrected 8/1/03

Re: IRO Case # M5-02-3049  
**New IRO Case # M5-04-1002-01**

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, Rule 133.308 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 IRO's, 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. 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 \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

### **History**

The patient sustained a low back sprain/strain injury in \_\_\_\_. He had eight weeks of physical therapy and six weeks of work hardening. He was found at MMI on 7/23/01 with a 0% impairment rating.

### **Requested Service(s)**

Work hardening program, impairment rating exam, FCE 7/27/01 – 9/26/01

### **Decision**

I agree with the carrier's decision to deny the requested services.

### **Rationale**

The patient had received extensive conservative therapy for his lumbar sprain/strain injury. A sprain/strain injury should readily resolve within six to eight weeks from initiation of treatment. An MRI report dated 5/16/01 states that there was disk degeneration present at the L5/S1 level. Thus the sprain/strain was superimposed on preexisting changes of the lumbar spine. With properly administered treatment, however, the sprain/strain injury still should have responded well to conservative treatment. Daily therapy documentation was not presented for this review, but the initial FCE indicates that treatment prior to the examination was unsuccessful in relieving the patient's low back symptoms. The final FCE demonstrates that the work hardening program also failed. On 7/23/01 the patient was found to be at MMI with a 0% rating. Treatment after that date was unnecessary. The documentation presented lacks supporting objective evidence to support a work hardening program.

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,