

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 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 1-2-04.

The IRO reviewed office visits, physical therapy services, medical disability exam and work hardening program rendered from 1-6-03 through 7-16-03 that were denied based upon "V".

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 May 24, 2004, 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	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
3-4-03 3-5-03	97545WH (2ours)	\$128.00	\$0.00	V	\$51.20 / hr X 2 = \$102.40	Medicine GR (II)(E) Rule 134.600 Rule 133.301(a)	On 3-3-03, preauthorization was obtained for 10 dates of work hardening; therefore, insurance carrier violated Rule 133.301(a) by retrospectively denying preauthorized treatment based upon medical necessity. Reimbursement of \$102.40 X 2 = \$204.80 is recommended.
3-4-03 3-5-03	97546WH	\$384.00 \$288.00	\$0.00	V	\$51.20 / hr X 6 = \$307.20 \$51.20 X 5 = \$256.00		Same rationale as above. Reimbursement of \$307.20 + \$256.00 = \$563.20 is recommended.
TOTAL							The requestor is entitled to reimbursement of \$768.00 .

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 1-6-03 through 7-16-03 in this dispute.

This Order is hereby issued this 15th day of December 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 20, 2004

AMENDED DECISION

MDR Tracking #: M5-04-1244-01
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 who has an ADL certification. The 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

According to the supplied documentation, it appears that the claimant injured his low back at work on ___ when he was lifting a pallet of batteries. A MRI was performed on 01/05/2001 that revealed a narrowed disc space at L4-5. A CT myelogram was performed on 02/20/2001, which revealed evidence of a broad based protrusion or herniation at L4-5. The claimant underwent lumbar injections, lumbar surgery (bilateral hemi-laminectomy, medial facetectomy and

foraminotomy), various medications and physical therapy. The claimant received a 17% whole person impairment on 07/25/2002, by _____. On 08/20/2002, the claimant changed treating doctors to _____. Active therapy was begun with _____ and the claimant was referred for a medical evaluation. _____ began active and passive therapy again. The claimant later underwent a work hardening program. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered including therapeutic exam, EMS, ultrasound, myofascial release, therapeutic exercises, joint mobilization, medical disability, and exams between 01/06/2003 and 07/16/2003.

Decision

I agree with the insurance company that the services reviewed were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, the therapy performed on the client is well documented. The claimant had a plethora of treatments performed prior to the dates in question. Since all of the therapies that were in dispute had been tried prior to the claimant being determined to be at MMI, then a continuation of these therapies is not considered reasonable or medically necessary. All of these treatments were redundant to prior sessions. It is commonly known that current literature does not support passive therapy beyond the initial 8-12 weeks of care. The claimant had had an adequate amount of active therapy and if the treating doctor felt additional treatment would improve the claimant's symptoms, then an appropriate home-based exercise protocol would be warranted. Since the claimant was under his previous PDL and needed to improve to return to work, then work hardening would be necessary to help with the claimant's de-conditioning. Monthly office visits are also considered necessary to evaluate and refer the claimant as needed.