

MDR Tracking Number: M5-04-2031-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 June 2, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. The IRO agrees with the previous determination that the office visit with manipulations for 01-02-03 was medically necessary. The work hardening for 02-07-03 was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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

On 06-10-04, 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\$ (Max. Allowable Reimbursement)	Reference	Rationale
01-07-03	97545-WH-AP 97546-WH-AP	\$512.00	\$409.60	F	\$64.00/hr x 8hrs	1996 MFG	These services were rendered at a CARF accredited facility, therefore will be reviewed in accordance with the 1996 MFG. Recommend additional reimbursement of \$102.40.
01-09-03 through 01-15-03 & 02-11-03 through 03-04-03	97545-WH-AP 97546-WH-AP	\$6144.00	\$0.00	No EOB	\$64.00/hr x 24hrs \$64.00/hr x 72hrs	1996 MFG	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA's reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. Recommend reimbursement of \$6144.00.
02-12-03 02-17-03 02-24-03	99361 99361 99361	\$53.00 \$53.00 \$53.00	\$0.00	No EOB	\$53.00 \$53.00 \$53.00	1996 MFG	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA's reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996

							Medical Fee Guideline. Recommend reimbursement of \$159.00
TOTAL		\$6815.00					The requestor is entitled to reimbursement of \$6405.40.

This Findings and Decision is hereby issued this 22nd day of October 2004.

Patricia Rodriguez
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 Order is applicable for dates of service 01-02-03 through 03-04-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 21, 2004

RE:

MDR Tracking #: M5-04-2031-01

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.

All of the documentation appears to be supplied from the provider which included a request for a MDR, MRI reports, office visits, FCE reports and daily notes.

Clinical History

According to the supplied documentation, it appears that the claimant sustained an injury to her low back when she fell down some stairs on _____. The claimant was began treatment with _____. A CT scan dated 07/15/2002 reveals a relatively subacute healing comminuted nondisplaced fracture of the coccyx. A CT scan of the lumbar spine reveals a 2 mm disc protrusion at L4-5 and a 3 mm disc protrusion at L5-S1. The claimant underwent injections to her lumbar and coccyx regions. The claimant underwent passive and active modalities. The claimant began a work hardening program on 01/06/2003 and ceased the program on 03/06/2003. Office visits continue and _____ gave the claimant a 10% whole person impairment on 03/15/2004. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the outpatient services including office visits with manipulations and work hardening rendered on 01/02/2003 and 02/07/2003.

Decision

I agree with the treating doctor that the services rendered on 01/02/2003 were medically necessary. I agree with the carrier that the services rendered on 02/07/2003 were not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears that the claimant underwent a typical conservative treatment protocol. The claimant began her care with passive modalities with a

progression to active therapy. Since the claimant did not respond, the claimant underwent injections to her coccyx and to her lumbar spine. At this time, it appears that the claimant still had some residual pain and it would be necessary for the claimant to be evaluated by her treating physician to determine the necessary course of her care. The office visits date 01/02/2003 was medically necessary to evaluate the injury that the claimant sustained on _____. The claimant began a work hardening program on 01/06/2003. After a trial of 20 work hardening sessions, objective findings would be necessary to evaluate the need of continued WH. The documentation did not report another FCE until the end of 02/2003. The 01/02/2003 FCE reported deficiencies in the claimant's ability to return to work. After 20 work hardening sessions, the supplied therapy notes indicate that the claimant was performing enough activity to return to her normal duty work PDL of medium. The 02/07/2003 work hardening session is not objectively supported; therefore it is not reasonable in the treatment of her compensable injury.