

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2040.M5

MDR Tracking Number: M5-04-2323-01

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 March 26, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The work hardening initial hour and each additional hour (97545-WH & 97546-WH) and office visits (99211/99212) from 09-30-03 through 12-09-03 **were found** to be medically necessary. 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.

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

On 06-08-04, 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
10-01-03 thru 10-15-03	97545- WH-AP	\$128.00(2hrs) x 11 days= \$1408.00	\$0.00	E	\$64.00/hr	Medicare Fee Schedule, Rule 134.202(e)(5)(c)	Requestor submitted a copy of the Benefit Dispute Agreement that states parties agree the compensable injury of ___ does extend to include the lumbar spine. Therefore, payment recommended in the amount of \$1408.00.
10-01-03 thru 10-15-03	97546- WH-AP	\$384.00(6hrs) x 10 days= \$3840.00 and \$320.00(5hrs) x 1 day= \$320.00	\$0.00	E	\$64.00/hr	Medicare Fee Schedule, Rule 134.202(e)(5)(c)	Requestor submitted a copy of the Benefit Dispute Agreement that states parties agree the compensable injury of ___ does extend to include the lumbar spine. Therefore, payment recommended in the amount of \$4160.00.
10-16-03	99211	\$26.94	\$0.00	E	\$26.94	Medicare Fee Schedule, Rule 134.202	Requestor submitted a copy of the Benefit Dispute Agreement that states parties agree the compensable injury of ___ does extend to include the lumbar spine. Therefore, payment recommended in the amount of \$26.94.
10-16-03 thru 11-07-03	97545- WH-AP	\$128.00(2hrs) x 16 days= 2048.00	\$0.00	No EOB's	\$2048.00	Medicare Fee Schedule, Rule 134.202(e)(5)(c)	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$2048.00.
10-16-03 thru 11-07-03	97546- WH-AP	\$384.00(6hrs) x 15 days=\$5760.00 and \$256 (4hrs) x 1 day =\$256.00	\$0.00	No EOB's	\$6016.00	Medicare Fee Schedule, Rule 134.202(e)(5)(c)	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$6016.00.
11-07-03 12-04-03	97750- FC 97750- FC	\$295.52 (\$36.94 x 8units) \$443.28 (\$36.94 x 12units)	\$0.00 \$0.00	No EOB	\$295.52 \$443.28	Medicare Fee Schedule, Rule 134.202 (e)(4)	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the Medicare Fee Schedule. Recommend reimbursement of \$738.80
TOTAL							The requestor is entitled to reimbursement of \$ 14397.74.

This Findings and Decision is hereby issued this 12th 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) and in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); 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 09-30-03 through 12-09-03 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 12th day of October 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution
Medical Review Division
HHB/pr

MEDICAL REVIEW OF TEXAS
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NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 5/9/04

TWCC Case Number:
MDR Tracking Number: M5-04-2323-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

May 17, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports shoulder injury, inguinal injury and low back injury after a stack of drywall fell on him at this place of employment. He apparently presented initially to the ___ where x-rays were taken and OTC medication was given. The patient later presents for chiropractic care with Dr. K and Dr. P where additional physical therapy appears to be performed. He was referred to a Dr. R for right inguinal hernia repair. He had a Left Shoulder MRI and was referred to a Dr. C for rotator cuff surgical repair. The patient appears to begin work hardening/conditioning program on 09/30/03 with another chiropractor, Dr. N and then another chiropractor, Dr. F through 12/09/03.

REQUESTED SERVICE(S)

Determine medical necessity for requested Work Hardening/Conditioning (97545/97546) and office visits (99211/99212) for dates in dispute 09/30/03 through 12/09/03.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Medical necessity for Work Hardening/Conditioning (97545/97546) and office visits (99211/99212) is generally supported by documentation provided, and does appear to meet the generally accepted criteria for patient selection. With multiple areas of surgical repair, this level of treatment does appear reasonable and necessary.

Schonstein E, Kenny DT, Keating J, Koes BW. Work conditioning, work hardening and functional restoration for workers with back and neck pain (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Nicholson, G.G. "Rehabilitation of Common Shoulder Injuries." *Clin in Sports Med.* 1989 8: (4) pg. 633-655.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.