

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

SOAH DOCKET NO. 453-05-0540.M5

MDR Tracking Number: M5-04-3261-01

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 05-27-04.

The IRO reviewed work hardening, work hardening each additional hour and conference rendered from 11-07-03 through 12-24-03 that were 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 07-14-04, 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.

CPT code 97750-FC for date of service 09-16-03 denied with denial code F. The respondent raised no other issues for denial. Reimbursement is recommended in the amount of \$428.24.

This Findings and Decision is hereby issued this 12th day of August 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 09-16-03 through 12-24-03 in this dispute.

This Order is hereby issued this 12th day of August 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/dlh

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 8/5/04

TWCC Case Number:	
MDR Tracking Number:	M5-04-3261-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

August 2, 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

Patient is a 21-year-old female assistant manager for a fast food restaurant who, on ___ while at work, injured her neck and lower back. She stated that on that date, she was on the counter checking the ice machine when she lost her balance and fell, landing on the flat of her back. Two days later, she began conservative chiropractic treatment, including physical therapy. On 09/16/03, a functional capacity evaluation demonstrated that she was incapable of performing the necessary physical demand level to return to full-duty, so she was referred to a work hardening program.

REQUESTED SERVICE(S)

Work hardening, initial (97545-WH-AP), work hardening/each additional hour (97546-WH-AP), and physician team conferences (99361) for dates of service 11/07/03 through 12/24/03.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

In this case, the documentation submitted well established that the patient sustained a compensable injury, and – following

chiropractic care including physical therapy – she continued to be symptomatic, had psychological overlay, and did not meet the physical demand requirements to return to her regular employment. After an 8-week work hardening program, the documentation also showed that not only did the patient's pain levels decrease, but both her range of motion and her physical demand level increased and she was successfully returned to full-duty on 01/05/04. Therefore, this treatment met the statutory requirements of Texas Labor Code 408.021 as being medically necessary in that it relieved the patient's symptoms, promoted recovery, and enhanced her ability to return to work.

Reviewer's Note: Although the explanation of benefits (EOBs) in this case stated that "payment was withheld as peer review indicates documentation does not support the treatment to be medically reasonable and/or necessary," no peer review was furnished for review. In fact, other than the EOBs, nothing whatsoever was supplied to support the carrier's position in this case.