

MDR Tracking Number: M5-04-3461-01

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 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 dispute was received on 6-10-04.

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** 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.

The Range of motion measurements/report, office visit, therapeutic exercises and work hardening program from 7-2-03 through 11-21-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

The Range of motion measurements/report, office visit, therapeutic exercises and work hardening program from 7-2-03 through 11-21-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On July 19, 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.

Regarding CPT Code 97750-FC for date of service 11-19-03: Rule 134-202 (e)(4) states (4) A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Information was submitted which reveals that this is a discharge FCE test. The requester is billing for a 3 hour FCE or \$443.28. Recommend reimbursement of \$443.28.

This Finding and Decision is hereby issued this 1st day of October, 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Pursuant to 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) for dates of service through July 31, 2003; 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 Decision is applicable for dates of service 7-2-03 through 11-21-03 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 1st day of October, 2004.

Hilda H. Baker, Manager
Medical Dispute Resolution

Medical Review Division

August 26, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3461-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided

by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 25 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his back when he attempted to lift a box weighing approximately 50 pounds. A MRI of the lumbar spine performed on 7/9/03 showed posterior central annular tears at L4-5 and L5-S1. The diagnoses for this patient have included lumbar strain, L4-5 and L5-S1 posterior annular tears of the disc, and right lower extremity radiculopathy. Treatment for this patient's condition has included injections, work hardening program, chiropractic care and manipulation, and physical therapy.

Requested Services

Range of motion measurements/report, office visit, therapeutic exercises and work hardening program from 7/2/03 through 11/21/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. MRI report 7/9/03
2. Procedure note/evaluation note 7/28/03
3. Texas Imaging notes 8/27/03 – 3/31/04
4. SOAP notes 8/8/03 – 11/21/03
5. Ergos exam 10/23/03

Documents Submitted by Respondent:

1. Peer Review 8/27/03
2. Work Hardening Review 10/6/03
3. Reconsideration 2/28/04, 3/31/04
4. MRI report 7/9/03
5. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 25 year-old male who sustained a work related injury to his back on ----- . The ----- chiropractor reviewer also noted that the diagnoses for this patient included lumbar strain, L4-5 and L5-S1 posterior annular tears of the disc, and right lower extremity radiculopathy. The ----- chiropractor reviewer further noted that treatment for this patient's condition has included injections, work hardening program, chiropractic care and manipulation, and physical therapy. The ----- chiropractor reviewer explained that although this patient had responded slowly to the treatment rendered, the patient did respond. The ----- chiropractor reviewer also explained that the treatment rendered to this patient is appropriate and medically necessary. Therefore, the ----- chiropractor consultant concluded that the range of motion measurements/report, office visit, therapeutic exercises and work hardening program from 7/2/03 through 11/21/03 were medically necessary to treat this patient's condition.

Sincerely,