

MDR Tracking Number: M5-04-3619-01

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 (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 June 24, 2004.

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. The work hardening rendered on 7/9/03 through 8/7/03 was found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On September 14, 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	MAR\$	Rationale
6/27/03	97750-FC	\$300.00	\$0.00	L	\$300.00	The requestor has not submitted relevant information to support the carrier's denial of "L-Not TD approved treatment." Therefore reimbursement is not recommended.
7/8/03	97545-WH-AP	\$128.00	\$0.00	F	\$128.00	According to 1996 Medical Fee Guideline (II)(E)(5), the requestor is entitled to reimbursement for the work hardening program in the amount of \$64.00/hour. Reimbursement is recommended in the amount of \$2,484.00.  According to the 1996 Medical Fee Guideline (I)(E)(2)(A), the requestor is entitled to reimbursement of the FCE in the amount of \$200.00.
7/8/03	97546-WH-AP	\$320.00	\$0.00	F	\$320.00	
7/14/03	97545-WH-AP	\$128.00	\$0.00	F	\$128.00	
7/15/03	97546-WH-AP	\$320.00	\$0.00	F	\$320.00	
7/21/03	97545-WH-AP	\$128.00	\$0.00	F	\$128.00	
7/22/03	97546-WH-AP	\$320.00	\$0.00	F	\$320.00	

7/23/03	97546-WH-AP	\$192.00	\$0.00	F	\$192.00	
7/23/03	97750-FC	\$200.00	\$0.00	F	\$200.00	
7/25/03	97545-WH-AP	\$128.00	\$0.00	F	\$128.00	
7/29/03	97545-WH-AP	\$128.00	\$0.00	F	\$320.00	
7/30/03	97546-WH-AP	\$300.00	\$0.00	F	\$300.00	
8/1/03	97546-WH-CA	\$320.00	\$0.00	598	\$320.00	Review of the carrier EOBs dated 8/27/03 revealed the carrier has denied reflects payment as non-CARF accredited. Communication with the J.H. on 10/6/04 revealed no payment has been received for dates of service 8/1/03, 8/4/03 and 8/6/03. Therefore, the disputed charges will be reviewed according to the TWCC Rule 134.202 (e)(5)(C). The requestor is entitled to reimbursement for a CARF accredited program. Recommend reimbursement in the amount of \$896.00.
8/1/03	97545-WH-CA	\$128.00	\$0.00	598	\$128.00	
8/4/03	97546-WH-CA	\$320.00	\$0.00	598	\$320.00	
8/4/03	97545-WH-CA	\$128.00	\$0.00	598	\$128.00	
8/6/03	97546-WH-CA	\$320.00	\$0.00	No EOB	\$320.00	Review of the requestors and respondents documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA 1500s reflected proof of submission. Therefore, the disputed charges will be reviewed according to the TWCC Rule 134.202 (e)(5)(C). The requestor is entitled to reimbursement for a CARF accredited program. Recommend reimbursement in the amount of \$1,024.00.
8/6/03	97545-WH-CA	\$128.00	\$0.00	No EOB	\$128.00	
	97546-WH-CA	\$256.00	\$0.00	No EOB	\$256.00	
9/4/03	97546-WH-CA	\$320.00	\$0.00	No EOB	\$320.00	
TOTAL			\$0.00			Reimbursement is recommended in the amount of \$4,604.00.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 to dates of service 6/27/03 through 9/24/03 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 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
 Medical Dispute Resolution Officer  
 Medical Review Division

MQO/mqo

September 10, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-3619-01**  
**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 48 year-old female who sustained a work related injury on ----- . The patient reported that while at work as a truck driver she injured her right knee, right shoulder, neck, and upper and lower back when she was involved in a motor vehicle accident. The patient was taken by ambulance to the emergency room where she was evaluated. On 5/1/03 the patient underwent an MRI of the cervical and lumbar spine and right knee that indicated mild hypertrophic cervical facet joint arthropathy at C3-4 and C4-5 bilaterally, a 2-3mm posterior central disc protrusion at L4-5, mild disc dehydration and small annular tears at L4-5, severe hypertrophic lumbar facet joint arthropathy at L4-5 and L5-S1 bilaterally, a small to moderate size right knee joint effusion with plica and debris in the suprapatellar recess, mild degenerative hypertrophic change in all three compartments of the right knee joint, and a small anterior soft tissue contusion with edema, inflammatory change and soft tissue swelling in the infrapatellar region. A EMG/NCV was performed on 5/2/03. The diagnoses for this patient have included displacement cervical intervertebral disc without myelopathy, neck sprain and strain, and thoracic sprain/strain. Treatment for this patient's condition has included chiropractic treatment, electrical stimulation, exercise and stretching and a work hardening program.

### Requested Services

Work Hardening Program 97545/97546 from 7/9/03 through 8/7/03.

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

#### *Documents Submitted by Requestor:*

1. MDR Request 6/22/04
2. WC/WH Program Daily Notes 7/1/03 – 8/8/03
3. Psychological Evaluation Report 7/25/03
4. MRI report 5/1/03
5. EMG/NCV report 5/2/03

#### *Documents Submitted by Respondent:*

1. No documents submitted

### Decision

The Carrier's denial of authorization for the requested services is overturned.

### Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 48 year-old female who sustained a work related injury to her right knee, right shoulder, neck and upper and lower back on -----.

The ----- chiropractor reviewer also noted that the diagnoses for this patient have included displacement cervical intervertebral disc without myelopathy, neck sprain and strain, and thoracic sprain/strain. The ----- chiropractor reviewer further noted that the treatment for this patient's condition has included chiropractic treatment, electrical stimulation, exercise and stretching and a work hardening program. The ----- chiropractor reviewer explained that although the patient responded slowly to the treatment rendered, she did respond favorably. The ----- chiropractor reviewer also explained that the patient sustained several spinal injuries that required extensive treatment. Therefore, the ----- chiropractor consultant concluded that the Work Hardening Program 97545/97546 from 7/9/03 through 8/7/03 were medically necessary to treat this patient's condition.

Sincerely,