MDR Tracking Number: M5-03-0256-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

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.

On February 13, 2003, 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.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
10-3-01	95900	$265.00	$0.00	N	$64.00 per nerve	Medicine GR (IV)(D)	Motor nerve study report supports testing of Peroneal and posterior Tibial nerves; therefore, reimbursement of 4 X $64.00 = $256.00 is recommended.
	95904	$128.00	$0.00	N	$64.00 per nerve	Medicine GR (IV)(D)	Sensory nerve study report supports testing of Sural nerves; therefore, reimbursement of 2 X $64.00 = $128.00 is recommended.
	95935	$318.00	$0.00	N	$53.00 per extremity	Medicine GR (IV)(B)	H and F wave studies were performed on lower extremities; therefore, reimbursement of 4 X $53.00 = $212.00 is recommended.
11-21-01 11-26-01	97545WH 97546WH	$102.40 $307.20	$0.00	N	$51.20 /hr for Non CARF	Medicine GR (II)(C)	The requestor noted in work hardening notes that

11-27-01 11-28-01 11-30-01 12-4-01 12-5-01 12-6-01 12-18-01 12-19-01					accredited program	and (E)	claimant attended work hardening from 8 a.m. to 4 p.m., for a total of 7 hours on 11-21-01, 11-23-01, 11-26-01, 11-27-01, 11-28-01, 11-30-01, 12-3-01, 12-4-01, 12-5-01, 12-6-01, 12-18-01 and 12-19-01. The requestor noted in work hardening notes that claimant attended work hardening from 8 a.m. to 3:45 p.m., for a total of 7 hours on 11-23-01. Work hardening reports support billing of work hardening program. Reimbursement per *Medical Fee Guideline* for work hardening 11 dates for 7 hours X $51.20 = $3942.40. Reimbursement per *Medical Fee Guideline* for work hardening 1 date for 6hours 45 minutes X $51.20 = $345.60. Total recommended for WH program = $4288.00
TOTAL							The requestor is entitled to reimbursement of $4884.00

This Decision is hereby issued this 2nd day of July 2003.

Elizabeth Pickle
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 $4884.00 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 9-18-01 through 1-9-02 in this dispute.

This Order is hereby issued this 2nd day of July 2003.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

December 9, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0256-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ 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 ___ external review panel. ___ 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, ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 56 year-old male who sustained a work related injury to his back on ___ when he was lifting a stack of papers and twisted to the right resulting in lower back pain. The patient was diagnosed with lumbar sprain. The patient also had an X-Ray and MRI. Treatment included medications, spinal manipulation, work hardening, myofascial release and manual traction, group therapy counseling sessions, and acupuncture for relaxation and sleep. He has also underwent a pain and mental health evaluation that indicated patient would benefit from a pain management program.

Requested Services

Somatosensory testing, work hardening, and fuctional capacity evaluations for dates 12/11/01, 12/12/01, 12/20/01, 12/21/01, 12/26/01, 12/27/01, 1/4/02, and 1/9/02.

Decision

The Carrier's denial of coverage for these services is upheld.

Rationale/Basis for Decision

___ chiropractor reviewer explained that medical records provided do not document medical necessity for treatments rendered. ___ chiropractor consultant indicated that the available records do not document the he responded to chiropractic care or substantiate the he required these services or treatments. Therefore, ___ chiropractor consultant has concluded that the Somatosensory testing, work hardening, functional capacity evaluations of 12/11/01, 12/12/01, 12/21/01, 12/26/01, 12/27/01, 1/4/02, and 1/9/02, were not medically necessary for the treatment of this patients condition.

Sincerely,