MDR Tracking Number: M5-03-0939-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 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. This dispute was received on 12-2-02.

The IRO reviewed work hardening program rendered from 12-3-01 to 12-7-01 that were denied based upon "U".

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(q)(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 May 7, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

Services that were denied without an EOB will be reviewed in accordance with *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
12-10-01 12-11-01 12-12-01 12-13-01 12-14-01 12-17-01 12-18-01 12-19-01 12-21-01	97545WH (2 hours)	$128.00	$0.00	No EOB	$51.20/hr for Non-CARF Accredited program	Medicine GR (II)(E) Rule 133.307(g)(3)	Work hardening reports to support billed service were not submitted. Reimbursement is not recommended.
12-10-01	97546WH	$384.00	$0.00	No	$51.20/hr for Non-	Medicine GR	Work hardening

12-11-01 12-12-01 12-13-01 12-14-01 12-17-01 12-18-01 12-19-01 12-21-01	(6 hours)			EOB	CARF Accredited program	(II)(E) Rule 133.307(g)(3)	reports to support billed service were not submitted. Reimbursement is not recommended.
12-17-01	99080 (237 pgs)	$118.50	$0.00	No EOB	$.50 page	Rule 130.6(r)	Reports were sent to Designated doctor; therefore, reimbursement of $118.50 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$118.50.**

This Decision is hereby issued this 3rd day of September 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 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 12-3-01 through 2-21-02 in this dispute.

In accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee.

This Order is hereby issued this 3rd day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

February 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0939-01

___ 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 the ___ external review panel. 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 57 year-old male who sustained a work related injury on ___. The patient reported that while at work as a truck driver, he released the clutch on the truck he was driving causing the truck to jerk. The patient reported that when the truck jerked, the patient hit his head on the back of the seat causing immediate pain in his neck. The patient underwent X-Rays and an MRI. The patient was treated with physical therapy and pain medications. The patient was evaluated by a neurosurgeon who recommended surgery and was performed on 1/12/01. The diagnoses for this patient included postlaminectomy syndrome of cervical region, myofasical pain syndrome, and muscular deconditioning syndrome.

Requested Services

Work Hardening program from 12/3/01 through 12/7/01.

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 the patient sustained a work related injury on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included postlaminectomy syndrome of cervical region, myofascial pain syndrome, and muscular deconditioning syndrome. The ___ chiropractor reviewer further noted that the patient was treated with physical therapy and pain medications. The ___ chiropractor reviewer explained that the work hardening program from 12/3/01 through 12/7/01 was medically necessary and appropriate. Therefore, the ___ chiropractor consultant concluded that the work hardening program from 12/3/01 through 12/7/01 were medically necessary to treat this patient's condition.

Sincerely,

___