MDR Tracking Number: M5-03-1046-01

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. This dispute was received on 7-24-02.

The IRO reviewed work hardening and office visits rendered from 7-24-01 through 8-17-01 that were denied based upon "U".

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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 21, 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:

Neither party submitted audit summaries for services identified as "No EOB"; therefore, these will be reviewed in accordance with the Commission's *Medical Fee Guideline.*

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
7-24-01	97750FC	$500.00	$0.00	No EOB	$100.00/hr	Medicine GR (I)(E)(2)(a)	The requestor did not note the time on FCE report; therefore, unable to determine how much time was spent; therefore, the

							minimum of $100.00 is recommended.
TOTAL							The requestor is entitled to reimbursement of **$100.00**

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 7-24-02 through 8-17-02 in this dispute.

This Decision and Order is hereby issued this 8th day of October 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

June 17, 2003

MDR Tracking #: M5-03-1046-01

___ 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 male who sustained a work related injury on ___. The patient reported that he had slipped and fell while at work injuring his back. The patient was evaluated for this injury in January 2001. The patient reportedly injured his left shoulder, left elbow, cervical and lumbar spine.

Requested Services

Work Hardening and office visits from 7/24/01 through 8/17/01.

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the patient had reportedly injured his left shoulder, left elbow, cervical and lumbar spine. The ___ chiropractor reviewer explained that after a review of the documents provided, the records do not support the medical necessity of the work hardening program and office visit on 7/24/01 through 8/17/01.

Therefore, the ___ chiropractor consultant has concluded that the work hardening and office visits from 7/24/01 through 8/17/01 were not medically necessary to treat this patient's condition.

Sincerely,