MDR Tracking Number: M5-03-2094-01

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 04-23-03. In accordance with Rule 133.307(d)(1) A dispute on a carrier shall be considered timely if it is filed with the division no later then one year after the dates of service in dispute therefore date of service 04-16-02 in dispute is considered untimely and will not be address in this review.

The IRO review work hardening rendered from 07-01-02 through 07-10-02 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 for work hardening. Consequently, the requestor is not owed a refund of the paid IRO fee.

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 07-09-03, 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. Relevant information was not submitted by the requestor in accordance with Rule 133.309 (g)(3) to confirm delivery of service for the fee component for date of service 12-04-02 in this dispute. Therefore reimbursement is not recommended for 12-04-02.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
01-08-03	99214	$81.65	0.00	No EOB	$71.00	MFG /EM GR (VI)(B)	Soap notes support delivery of service. Recommended Reimbursement $ 71.00
	99080	$15.00	0.00		DOP	Rule 129.5	Work Status report was submitted to support service rendered therefore, recommended reimbursement $15.00
	99080	$15.00	0.00				Work Status report was not submitted unable to confirm service rendered therefore, reimbursement is not recommended

TOTAL	$111.65		The requestor is entitled to reimbursement of **$** 96.00

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 01-08-03 in this dispute.

This Decision is hereby issued this 12th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 1, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-2094-01
IRO Certificate #: 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in physical medicine and rehabilitation which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient was injured on ___ when he bent over to pickup some clothes and felt immediate back pain upon standing back up. A lumbar MRI from 04/15/02 revealed an L4-5 symmetric annular bulge. He has undergone physical therapy and eventually a work hardening program.

Requested Service(s)
Work hardening from 07/01/02 through 07/10/02

Decision
It is determined that the work hardening from 07/01/02 through 07/10/02 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The patient apparently received more work hardening time than was approved. In reviewing the medical records, there were no descriptive therapy notes from the work hardening program other than the 07/03/02 note labeled vocational class. In the appeal letter, the improvement from the May functional capacity evaluation (FCE) compared to the July one was cited. It is possible that the patient had reached a plateau earlier, or he may have continued to improve. Without documentation of the need for ongoing therapies, and documentation of interval progress, such as team conference or review sessions, the additional work hardening sessions cannot be justified. Therefore, it is determined that the work hardening from 07/01/02 through 07/10/02 was not medically necessary.

Sincerely,