MDR Tracking Number: M5-03-2419-01

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, 133.307 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 05-30-03.

The IRO reviewed work hardening rendered on 02-03-03 that was 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(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. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 8-12-03, 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.

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

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
2/24/03 through 3/6/03 (7 DOS)	97545-WH	$716.80 ($102.40 2 units X 7 DOS)	$0.00	A, Z	$64.00 per hour	MFG MED GR (II)(E)(3-5)	A, Z – Preauthorization required for non-CARF providers. Authorization was not obtained

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
							therefore no reimbursement recommended.
2/24/03 through 3/6/03 (7 DOS)	97546-WH	$2,150.40 ($307.20 6 units X 7 DOS)	$0.00	A, Z	$64.00 per hour	MFG MED GR (II)(E)(3-5)	A, Z – Preauthorization required for non-CARF providers. Authorization was not obtained therefore no reimbursement recommended.
12/10/02	99499-RP	$50.00 (1 unit)	$0.00	A	DOP	96 MFG E/M GR (XXIV)(A)	A- Denied for preauthorization. RME was not requested by carrier or ordered by TWCC therefore no reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
2/12/03	99203	$74.00 (1 unit)	$0.00	A	$48.00	96 MFG E/M GR (VI)(A)	A – Denied for preauthorization. Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
3/14/03	99202	$50.00	$0.00	F	$50.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
TOTAL		$3,041.20	$0.00				The requestor is not entitled to any reimbursement.

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 12-10-02 through 03-14-03 in this dispute.

This Order is hereby issued this 26th day of March 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

August 7, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2419-01

___ 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 35 year-old male who sustained a work related injury on ___. The patient reported that while at work he attempted to lift an 80-pound bag of cement when he began to experience low back pain. The patient has been treated conservatively with work conditioning. The patient has been diagnosed with a 2-3mm disc bulge in the lumbar spine. The patient is reported to not be a surgical candidate.

Requested Services
Work Hardening on 2/3/03.

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 this case concerns a 35 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient include a 2-3mm disc bulge in the lumbar spine. The ___ chiropractor reviewer further noted that the patient has been treated with work conditioning from December 2002 through February 2003. The ___ chiropractor reviewer indicated that the patient had a documented disc problem that could not be surgically treated. The ___ chiropractor reviewer explained that conservative care was a reasonable treatment for this patient's condition. The ___ chiropractor reviewer also explained that the visit on 2/3/03 falls in the middle of the work hardening program and would be considered medically necessary.

Therefore, the ___ chiropractor consultant concluded that the work Hardening on 2/3/03 was medically necessary to treat this patient's condition.

Sincerely,