MDR Tracking Number: M5-03-2482-01

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 06-05-03.

The IRO reviewed functional capacity evaluation rendered on 07-30-02 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 03-17-04, 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
9-4-02 through 9-12-02 (2DOS)	97545-WH	$204.80 ($102.40 1 unit X 2 DOS)	$0.00	A	$64.00 per hour	96 MFG MED GR (II)(E)(3-5)	A- Denied for preauthorization. Requestor provided proof of preauthorization. Reimbursement recommended in the amount of $64.00 X 2 DOS = $128.00
9-4-02 through 9-12-02 (2 DOS)	97546-WH	$512.00 ($51.20 per unit X 10 units)	$0.00	A	$64.00 per hour	96 MFG MED GR (II)(E)(3-5)	A- Denied for preauthorization. Requestor provided proof of preauthorization. Reimbursement recommended in the amount

							of $51.20 X 10 units = $512.00
9-5-02 through 9-10-02 (3 DOS)	97545-WH	$307.20 ($102.40 1 unit X 3 DOS)	$0.00	D	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $64.00 X 3 DOS = $192.00

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$**	**Reference**	**Rationale**
9-5-02 through 9-10-02 (3 DOS)	97546-WH	$921.60 ($51.20 per unit X 18 units)	$0.00	D	$64.00 per hour	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $51.20 X 18 units = $921.60
9-5-02	99213-MP	$48.00 (1 unit)	$0.00	D	$48.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in the amount of $48.00
9-18-02	99080	$55.50	$0.00	T	DOP	Advisory 2002-11; Rule 133.307 (g)(3)(A-F)	T- Carrier denied outside of treatment guidelines. Treatment guidelines were abolished by statute effective 1-1-02. Review is per Rule 133.307 (g)(3)(A-F). Requestor did not submit relevant information to support DOP criteria. No reimbursement recommended.
TOTAL		$2,049.10	$0.00				The requestor is entitled to reimbursement in the amount of $1,801.60

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

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

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 07-30-02 through 09-18-02 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

August 4, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This worker was injured while lifting a large container of soda pop. She suffered an immediate onset of low back pain, as well as pain into the lower thoracic spine. MRI, which was interpreted by ___ was positive for a herniated disc at the level of L4/L5. The MRI was negative for spinal stenosis. She was treated with extensive conservative care to include work hardening and was not treated surgically, from the records received.

There was review of additional records from ___, but it contained no findings, only a statement attesting to a TWCC-73. The TWCC-73 restricted lifting to no more than 20 pounds. This was filed on September 12, 2002. The FCE performed on July 30, 2002 found that the patient was only able to perform light duty. Apparently this was the basis for the entry into a work hardening program.

DISPUTED SERVICES

The carrier has denied the medical necessity of a Functional Capacity Evaluation which was performed on July 30, 2002.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The carrier's own doctor agreed with the findings of the FCE and assigned light duty to the patient. The FCE clearly met the qualifications for the reasonableness of care, as it was used to determine the condition of the patient and actually did allow the treating doctor to formulate a treatment plan that was specific to the patient's need. There is little doubt that this test helped prevent guesswork in the treatment plan. Also, the treating doctor's position statement is correct in that the TWCC fee guidelines do allow for the performance of the initial FCE to assess the patient's condition. The reviewer feels that the FCE was clearly medically necessary for the treatment of this patient's condition.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,