

MDR Tracking Number: M5-03-2962-01

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 July 14, 2003.

The IRO reviewed work hardening program and FCE rendered from 7/25/02 through 8/14/02 denied based upon "V".

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.

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 February 10, 2004, 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	MARS	Reference	Rationale
7/15/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00	Rule 133.307 (g)(3)	Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note supports delivery of service. The requestor, is therefore, entitled to reimbursement in the amount of \$3,504.00.
	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/16/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		
	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/17/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		
	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/18/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		
	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/19/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		
	97546-WH-AP	\$256.00	\$0.00	P	\$256.00		
7/19/02	99213	\$55.20	\$0.00	P	\$48.00		
7/22/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		
	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/23/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00		

	97546-WH-AP	\$384.00	\$0.00	P	\$384.00		
7/26/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$256.00	\$0.00	N	\$256.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$256.00.
7/29/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$384.00	\$0.00	N	\$384.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
7/30/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.

	97546-WH-AP	\$256.00	\$0.00	N/P	\$256.00		Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$256.00.
7/31/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$384.00	\$0.00	N/P	\$384.00		Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/1/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.

	97546-WH-AP	\$384.00	\$0.00	N/P	\$384.00		Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/2/02	99213	\$55.20	\$0.00	No EOB	\$48.00	Rule 133.307 (g)(3)	Both the requestor and respondent failed to submit copies of EOBs. Therefore the disputed charge will be reviewed according to the <u>MFG</u> . Review of the SOAP note supports delivery of service. Reimbursement is recommended in the amount of \$48.00.
	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$320.00	\$0.00	N	\$320.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$320.00.
8/5/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.

	97546-WH-AP	\$384.00	\$0.00	N	\$384.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/7/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
8/7/02	97546-WH-AP	\$384.00	\$0.00	N/P	\$384.00	Rule 133.307 (g)(3)	Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/8/02	97545-WH-AP	\$128.00	\$0.00	P	\$128.00	Rule 133.307 (g)(3)	Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.

	97546-WH-AP	\$384.00	\$0.00	N/P	\$384.00		Review of the EOBs submitted for the dates of service denied by the carrier for "P" reveals that no payment was made to the requestor in order to recoup the overpayment. Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/15/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$384.00	\$0.00	N	\$384.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/16/02	97545-WH-AP	\$128.00	\$0.00	N	\$128.00	Rule 133.307 (g)(3)	Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$128.00.
	97546-WH-AP	\$384.00	\$0.00	N	\$384.00		Review of the office note meets the documentation criteria set forth by the <u>Medical Fee Guideline</u> . Reimbursement is recommended in the amount of \$384.00.
8/20/02	97750-FC	\$200.00	\$0.00	No EOB	\$200.00	Rule 133.307 (g)(3)	Both the requestor and respondent failed to submit copies of EOBs. Therefore the disputed charge will be reviewed according to the

							<u>MFG.</u> The requestor failed to submit copies of relevant information to support delivery of service. Reimbursement, is therefore, not recommended.
TOTAL		\$9,078.40	\$0.00		\$9,064.00		The requestor is entitled to reimbursement in the amount of \$8,864.00.

This Decision is hereby issued this 19th day of March 2004.

Margaret Q. Ojeda
 Medical Dispute Resolution Officer
 Medical Review Division
 MQO/mqo

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 7/15/02 through 8/16/02 in this dispute.

This Order is hereby issued this 19th day of March 2004.

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

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 8, 2004

Re: IRO Case # M5-03-2962

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured his lower back in ___ when he was lifting and carrying heavy tools. He had numerous medical evaluations and was treated with physical therapy, medication and a work hardening program.

Requested Service(s)

Work hardening 7/25/02 – 8/14/02

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient received an extensive course, around nine months, of physical therapy and work hardening with only temporary relief of his symptoms. On 2/8/02 an orthopedic surgeon noted that, "this patient is a surgical candidate now" yet the failed treatment continued for some seven months. The patient was placed at MMI on 7/30/02. After an MMI date all further treatment must be reasonable and effective in relieving symptoms or improving function. The patient did improve during the work hardening program, but his improvement was only temporary. On 10/26/02 it was reported that the patient was afraid to try further exercises because they increased discomfort and muscular spasms, and that his low back pain continued and was sometimes severe. This was after a year of conservative treatment. The patient had difficulty with the activities of daily living and was afraid to be active. On 11/19/02 it was reported that the patient's back pain was becoming more severe and that he had severe disk degeneration.

Notes on 7/3/02 from an orthopedic surgeon state that, "the patient continues to experience significant lumbosacral pain." This complaint followed six weeks of work hardening, indicating that the program had failed. The failure of conservative therapy does not establish a medical rationale for additional non-effective treatment. Based on the records provided for this review the patient plateaued in a diminished condition as of 7/25/02.

The documentation provided fails to show objective, quantifiable findings to support the necessity of the work hardening program.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.