MDR Tracking Number: M5-03-3018-01

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 07-22-03.

The IRO reviewed work hardening and team conference by physician rendered from 05-12-03, 05-13-03, 05-16-03, and 06-05-03 that were 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 for work hardening and team conference by physician. 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 September 16, 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:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
05-21-03 05-22-03 05-27-03 05-28-03 05-29-03 06-02-03 06-03-03	97545WH (7 dates of service of 2 hours total of 14 hours)	$896.00	0.00	A	$64.00	MFG MGR (II)(C) & (E)	Per Advisory 2001-14 preauthorization for work hardening or work conditioning programs are not required for CARF accredited providers. Soap notes confirm delivery of service. Recommended reimbursement $896.00 (14 hours at $64.00 per hour)

05-21-03 05-22-03 05-27-03 05-28-03 05-29-03 06-02-03 06-03-03	97546WH (7 dates of service of 4 hours total of 28 hours)	$1792.00	0.00	A	$64.00/hour	MFG MGR (II)(C) & (E)	Per Advisory 2001-14 preauthorization for work hardening or work conditioning programs are not required for CARF accredited providers. Soap notes confirm delivery of service. Recommended reimbursement $1792.00 (28 hour at $64.00 per hour)
05-23-03	99361	$53.00	0.00	A	$53.00		Soap notes do not confirm delivery of service. Reimbursement not recommended.
TOTAL		$2997.00					The requestor is entitled to reimbursement of **$** 2688.00

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

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 8-28-01 through 12-28-01 in this dispute.

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

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 2/19/04

MDR Tracking Number: M5-03-3018-01

September 3, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Available information suggests that this patient was injured at work on ___ and presented initially to an ___ and was seen for low back pain with a ___. Medications and physical therapy were prescribed, and MRI was ordered for 11/15/02. MRI findings are negative for discopathy or other acute pathology. Some mild pre-existing degenerative changes are noted in lower facet joints only. The patient is seen by a ___ for neurosurgical evaluation on 12/16/02 and is found to have chronic lumbar spondylosis without radiculopathy. ___ recommends that the patient undergo a two-week work conditioning program. The patient apparently requests a change of treating physicians in January of 2003 and begins seeing a chiropractor, ___ at ___. Neurodiagnostic studies are performed and found essentially negative. A number of Functional Abilities Evaluations are performed including strength and ROM tests as well as Temperature Gradient Studies. The patient is seen by a ___ for trigger point injections because of a failure to respond to conservative care. There are a number of Ergos Work Performance and Static Strength Tests performed by a ___ dated ***3/26/99, 3/27/99, 4/19/99, and 5/22/99*** in addition to those dated in 2003. Relevance to these test dates to current conditions is not explained in reporting. There are some Weekly Team Conference notes submitted on hand written forms on 4/25/03, 5/2/03, 5/12/03, 5/16/03 and 6/16/03 only. These notes appear to suggest attendance problems due to illness and family concerns. Some unsigned, computer generated, chiropractic work hardening notes are submitted from 5/13/03 to 6/5/03 by ___.

REQUESTED SERVICE(S)

Medical necessity for chiropractic services (work hardening, team conference by physician) for 5/12/03, 5/13/03, 5/16/03 and 6/5/03.

DECISION

Reverse previous decision. Medical necessity is supported concerning these services.

RATIONALE/BASIS FOR DECISION

Neurosurgical consultation with ___ from 12/16/02 does suggest medical necessity for work conditioning or work hardening for a two-week period of time. Though chiropractic notes, reports and test results appear confusing and clearly computer generated, the Team Conference component of documentation does appear reasonable and necessary in order to monitor patient progress.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent

documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.