

MDR Tracking Number: M5-02-1970-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division received the dispute on 1/24/02, therefore dates of service 1/10/01 through 1/23/01 are out of the one year jurisdiction and will not be addressed further in this Finding and Decision.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening and FCE's rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that work hardening and FCE's fees were the only fees involved in the medical dispute to be resolved. As the treatment, work hardening and FCE's was not found to be medically necessary, reimbursement for dates of service from 1/25/01 through 2/20/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 27, 2002

Re: IRO Case # M5-02-1970-01

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, Rule 133.308 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 IRO's, 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 also is a Certified Strength and Conditioning Specialist. 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, based on the medical records provided, is as follows:

History

The patient was reportedly injured in ___ while lifting someone out of a wheelchair. He felt pain to the neck, and middle and low back. He was prescribed physical therapy with manipulations.

Requested Service(s)

Work hardening 1/10/01 – 2/20/01
FCE's 1/31/01 and 2/20/01

Decision

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

Rationale

The documentation provided indicates that the patient responded very well to physical medicine treatment and manipulation. The treatment program was very extensive and the patient responded in a reasonable time for the diagnosis given. He had preexisting degenerative changes of the cervical and lumbar spine which could have possibly prevented him from returning to his pre-injury health status. An FCE performed 12/01/00 indicated that the patient had good strength in the upper and lower extremities. It was noted that he was functioning at the medium physical demand level. A physical demand analysis for the title of facility manager at his job site was noted to be medium work level.

A work hardening program was not necessary. It is possible that the patient could have progressed more with a few more weeks of a home-based strength and conditioning program.

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

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. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,