

MDR Tracking Number: M5-02-2038-01

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 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 functional capacity testing rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the functional capacity testing rendered was the only fee involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for date of service 9/13/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 23 day of, July 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Ex

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 certified by the State of Texas. 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

History

This case involves a 27-year-old patient injured on ____. He was diagnosed with a chest wall contusion. The patient received extensive conservative treatment and underwent numerous evaluations and extensive testing. Evaluations and testing confirmed the initial diagnosis of a soft tissue anterior chest contusion. The patient was reported to have reached MMI on 9/11/01.

Requested Service

FCE 9/13/01

Decision

I agree with the carrier's decision to deny the requested services on 9/13/01

Rationale

A physician examined the patient on 9/11/01 and determined that he had reached MMI and that no further diagnostic or medical treatment was necessary. The documentation and evaluations provided supports this conclusion. Further evaluation was totally unnecessary.

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

Sincerely,