

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 work hardening was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that work hardening fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 1-15-01 through 2-23-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 2nd day of July 2002.

Debra Hausenfluck
Medical Dispute Resolution Officer
Medical Review Division

DH/dh

April 18, 2002

Texas Workers' Compensation Commission
David R. Martinez, Chief
Medical Dispute Resolution
4000 South IH-35, MS 40
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR #: M5-02-2123-01
IRO Certificate No.: IRO 5055

Dear:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a practitioner of Chiropractic Medicine.

THE REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case #M5-02-2123-01, in the area of Chiropractic Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for Medical Dispute Resolution and reimbursement for a work hardening program.
2. Carrier's denial and stated reasons for denial.
3. Doctor's explanation of necessity of work hardening program.
4. HCFA-1500's.
5. Weekly reports from doctor's office.
6. Impairment rating, correspondence, and designated doctor's report.
7. FCE/March 21, 2000.
8. FCE/January 2, 2001.
9. Pre-program medical records.

B. SUMMARY OF EVENTS:

The patient sustained a work-related injury on ___, while working as a cook/food-prep, carrying a 70-pound bucket of carrots. The pain onset was immediate in the low lumbar region.

The patient has since seen numerous specialists, and various diagnostic studies have confirmed the diagnosis of a lumbar disk radiculopathy. A series of injections was performed with no true symptomatic benefit.

Some of the specialists suggest that greater invasive applications such as a neurostimulator and morphine pump are appropriate for pain management.

However, nearly all of the multi-disciplinary specialists in this case make references for the need for further physical therapy and ongoing medical care except ___, who states, "His opinion could be changed with additional information."

The designated doctor, ___ states that ongoing treatment is relevant even after the MMI date of 01/30/01 if the treating doctor feels that it is appropriate and if its application is determined by subjective and objective means of analysis.

C. OPINION:

1. I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE ABOUT THE ISSUE OF MEDICAL NECESSITY AND, THUS, THE ISSUE OF NON-PAYMENT FOR SERVICES RENDERED.
2. It is the opinion of this reviewer that ___ utilized objective means (FCE - 01/02/01) to render the decision to enroll the patient into a work hardening program. Further, it is evident that the rationale stated by the review agent is not applicable to this case because medical necessity is outlined by the designated doctor in his report when he states that further treatment will be appropriate if there is an objective means to determine its application. In this case, the FCE - 01/02/01 provides this data.
3. Screening criteria utilized takes reference with extracted rehabilitation protocols of the American Chiropractic Rehabilitation Board, strengthening guidelines set forth by the National Strength and Conditioning Association, referral data present in these records, and practice experience.
4. The work hardening services rendered by ___ were medically appropriate for work hardening reimbursement and medically necessary, per the data reviewed.

D. ADDITIONAL COMMENTS:

___ has not shown CARF affiliation in any of the documentation that I have reviewed.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 16 April 2002