

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee.

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 the only issue** to be resolved. The work hardening program was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the work hardening program charges.

This Finding and Decision is hereby issued this 19th day of July 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay 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 Order is applicable to dates of service 5/29/01 through 7/16/01 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 19th day of July 2002.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/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 Executive Director, 7/19/02.

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 5, 2002

Re: IRO Case # M5-02-2307-01

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, 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 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 physician who is Board Certified in Orthopedic Surgery. 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 medically necessary. Therefore, ___ disagrees 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 29-year-old male injured on ___ when he was struck with a forklift. He reportedly sustained multiple injuries including both knees and his left ankle. He underwent surgery on his left knee on 11/27/00, which involved arthroscopy with partial lateral meniscectomy and partial synovectomy. The patient's post-surgical recovery was slow. He was prescribed Work Hardening for the period 5/29/01 through 7/16/01.

Services in Medical Necessity Dispute

Work Hardening Program 5/29/01 through 7/16/01

Decision

I disagree with the carrier's decision to deny the work hardening program 5/29/01 through 7/16/01.

Rationale

A FCE was appropriately performed on 5/25/01. The patient's job demand was heavy, and he only performed at a light duty level on his initial FCE. Work hardening was implemented in an attempt to return the patient to his previous work status. The patient responded to work hardening with improvement in his functional capacity.

There appeared to be a lack of communication between physicians and the physical therapist about the patient's post-operative weight bearing status. This, along with the patient's pain, might have contributed to the patient's slower rehabilitation. However, it would be inappropriate to deny the patient proper treatment because his health care providers did not communicate appropriately. There is no evidence in the medical record that the treating physicians intentionally misdirected the patient to non-weight bearing status, which resulted in a deconditioned patient.

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,