

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 \$460.00** 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.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

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 9/24/02 through 10/12/01 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 7<sup>th</sup> 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, 7/11/02.

July 11, 2002

**REVISED CORRESPONDENCE**

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
4000 South IH-35, MS 48  
Austin, TX 78704-7491

Attention: Rosalinda Lopez

Re: Medical Dispute Resolution  
MDR #: M5-02-2308-01  
IRO Certificate No.: 5055

Dear Ms. Lopez:

THIS LETTER IS TO REPLACE THE LETTER OF 07/09/02 for the purpose of clarifying the year of the services in question.

The independent review, forwarded to you on 07/03/02, was performed by a matched peer with the treating health care provider. This case was reviewed by a Doctor of Chiropractic Medicine.

**THE REVIEWER OF THIS CASE DISAGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER. THE REVIEWER IS OF THE OPINION THAT THE WORK HARDENING PROGRAM WAS MEDICALLY NECESSARY FOR THE FOLLOWING DATES IN 2001: 9/24, 9/25, 9/26, 9/28, 10/01, 10/02, 10/04, 10/05, 10/08, 10/09, 10/11, and 10/12/01.**

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.

Sincerely,

**MEDICAL CASE REVIEW**

This is for \_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M5-02-2308-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment, dated 05/07/02, one page.
2. TWCC #60, Medical Dispute Resolution Request/Response, 3 pages.

3. TWCC #60, Table of Disputed Services form, for dates 09/24/01 through 10/12/01.
4. Explanation of payments from the carrier for dates 09/24/01 through 10/12/01, 23 pages.
5. Letter from \_\_\_\_, dated 01/18/02, 3 pages.
6. TWCC #60, dated 08/02/01.
7. Impairment rating report from \_\_\_\_, dated 08/02/01, 7 pages.
8. TWCC #73, dated 08/02/01.
9. \_\_\_\_, office notes and related reports, 32 pages, from 09/24/01 through 10/12/01.
10. FCE Initial Report from \_\_\_\_, dated 09/20/01, 27 pages.
11. Final FCE report from \_\_\_\_, dated 10/17/01, 21 pages.

B. SUMMARY OF EVENTS:

The patient was employed at \_\_\_\_ at the time of her Worker's Comp claim. At the time of her injury, she was employed as a senior manufacturing operator, working from 40 to 75 hours per week. Current complaints for this claim include bilateral hand, wrist, and arm pain.

This review is for retrospective medical necessity review of work hardening for dates 09/24/01 through 10/12/01.

C. OPINION:

I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

The carrier failed to supply any documentation to support their view of unnecessary treatment.

\_\_\_\_ letter of 01/18/02 and the discharge summary dated 10/12/01 were complete in supplying the necessary information to support the medical necessity of the work hardening program.

D. 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.

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Date: 11 June 2002