

MDR Tracking Number: M5-02-2311-01

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 work hardening rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the work hardening rendered was 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 7/23/01 to 8/10/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 5th day August 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 Executive Director 7/16/02, sent 8/5/02.

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 10, 2002

Re: IRO Case # M5-02-2311-01

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 physician who is Board Certified in Physical Medicine and Rehabilitation. 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 is 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 61-year-old female who was injured on ____. She was diagnosed with a spiral fracture of the shaft of the fifth metatarsal in the left foot. X-ray on 6/5/01 showed that the fracture had healed. She was started on physical therapy for strengthening, stretching and range of motion exercises. She reached was determined to be at maximum medical improvement on 7/20/01, and assigned a 0% whole person impairment. Functional capacity evaluation was done on 7/19/01, and she was found to be functioning at a light physical demand level. Her left ankle range of motion was found to be 60% less than the right in all planes of motion. Her muscle strength was +3/5 throughout the left ankle, and she had poor endurance. Work hardening was recommended, and she started this program on 7/26/01. The program consisted on eight-hour day physical therapy with psychological counseling one hour per week.

Requested Service

Work hardening program 7/26/01-8/10/01

Decision

I agree with the carrier's decision to deny the requested work hardening program.

Rationale

It is clear from the records that this patient was in need of further strengthening and conditioning of her left foot. She was not functioning at a high enough level to return to her job in housekeeping. However, there is no indication from the records that a multi-disciplinary approach was necessary. No psychological evaluation or screening report was provided. The patient would have benefited from a work conditioning program without the multi-disciplinary approach.

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,