

MDR Tracking Number: M5-02-2342-01

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 4/30/01 to 6/13/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th 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 Executive Director 7/16/02.

July 9, 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 #: M5-02-2342-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

THIS LETTER AND MEDICAL REVIEW IS TO REPLACE THE LETTER OF 06/13/02 which mis-stated that the physician reviewer agreed with the requestor. It should read as stated later in this correspondence that the reviewer agrees with the insurance carrier.

The independent review 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 AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER.

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 TWCC Case File #M5-02-2342-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment, dated 05/09/02, one page.
2. TWCC #60, Medical Dispute Resolution Request/Response, 2 pages.
3. TWCC #60, Table of Disputed Services, for dates 04/30/01 through 06/13/01, 3 pages.
4. TWCC #62, Explanation of Benefits, 5 pages from 04/30/01 through 06/13/01.
5. Letter from ___, dated 05/13/02.
6. Report of Medical Evaluation from ___, dated 06/25/01, 9 pages.
7. ___ Medical case review evaluation, dated 12/12/00, 2 pages.
8. Medical report from ___, dated 05/01/02, 2 pages.
9. ___ office visit notes, 58 pages.
10. Functional capacity evaluation, dated 04/30/01, 9 pages.
11. Functional capacity evaluation, dated 05/22/01, 11 pages.

B. SUMMARY OF EVENTS:

This patient is a 39-year-old female who was injured on _____. While working, she bent down to pick up a heavy box, and when standing up with the box, she felt a pop in her lower back. The same day apparently, she went to the company physician. The following day, she went to see _____ and has been under her care since that time.

This review is for medical dispute for denial of work hardening from dates 04/30/01 through 06/13/01.

C. OPINION:

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

Upon review of the documentation submitted, it is my opinion that _____ did not provide sufficient documentation of medical necessity as required by *TWCC Fee Guidelines 1996*, Medical Ground Rules, Section II, E, Work Hardening, specifically, #10, Exit/Discharge Summary, including the items listed under #9.

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.

Date: 11 June 2002