

MDR Tracking Number: M5-02-2347-01

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 office visit/evaluation and work hardening rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that office visit/evaluation and work hardening fees were the only fees involved in the medical dispute to be resolved. As the treatment, (office visit/evaluation and work hardening) was not found to be medically necessary, reimbursement for dates of service from 11/28/01 through 1/11/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 22, 2002

Re: IRO Case # M5-02-2347-01

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 was 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 40-year-old female who injured her back ___ while lifting a box. She developed pain in her low back radiating into her right buttock and posterior thigh, and some numbness in her right foot. She was diagnosed with lumbosacral sprain. An MRI was negative for a herniated disk. An EMG/Nerve conduction test showed no lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy. The patient was treated with multiple injections into the SI joint area, medications, and physical therapy. An initial FCE 11/27/01 rated the patient at the light to medium physical demand level. She had a fair tolerance to sitting, with increasing pain in her back after 10 minutes. The physical demands for her job required seven hours sitting, five minutes standing, 1 hour walking, maximum 50 lb. Lifting floor to waist, waist to shoulder and over head, maximum 50 lbs, carrying five feet. The patient was found to have a maximum leg lift of 64.5 lbs., maximum torso lift of 36 lbs., maximum arm lift waist to shoulder 28 lbs., maximum over head lift 35.5 lbs., ability to sit one hour, stand five minutes, walk 30 minutes. The patient participated in a multi disciplinary work hardening program 12/3/01 – 1/11/02. A FCE reported essentially no change in the patient's functional abilities following the work hardening program.

Requested Service(s)

Work hardening program 12/3/01-11/02, evaluation 11/28/01

Decision

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

Rationale

The FCE on 11/27/01 demonstrated the patient's inability to perform some of the tasks required for her job because of weakness and inability to tolerate certain positions for the necessary

length of time. However, there is no documentation that a multi-disciplinary approach was necessary. There was no psychological or vocational evaluation, and no evidence of any need for behavioral counseling. The patient's physical limitations could have been addressed with a single disciplinary work conditioning program.

No documentation was provided regarding the 11/28/01 evaluation, so no opinion can be rendered on that service.

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,