

MDR Tracking Number: M5-02-2351-01

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 FCE and work hardening program were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the FCE and work hardening fees were 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 11-19-01 through 12-28-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of August 2002.

Dee Z. Torres, Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

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.

Enclosure: IRO Decision

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

August 22, 2002

**Re: IRO Case # M5-02-2351-01**

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 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 42-year-old female who on \_\_\_ was stepping out of a van onto a stool and fell backwards, hitting her head and neck on the van. She later had neck pain, occipital pain, headaches and dizziness. She was treated with active physical therapy and passive modalities. She was diagnosed with post-concussion syndrome and cervicalgia. An MRI was significant for pituitary adenoma. She was later diagnosed with empty sella. There was no further treatment for her head injury.

An initial FCE on 9/5/01 rated the patient's physical demand level as sedentary light. Her job demands as a Head Start teacher were classified as light medium level. The patient continued with physical therapy, and a work hardening program was recommended. Another FCE on 11/16/01 rated the patient's physical demand level as light, and the work hardening program was recommended again. The patient was treated in a work hardening program 11/19/01 through 12/28/01. An FCE 12/17/01 rated the patient's ability to work at the medium light level for activity above the waist, and light for activity below the waist. Completion of two more weeks in the work hardening program was recommended. An FCE after completion of the work hardening program, 1/3/02 rated the patient as able to work at the light medium physical demand level. It was recommended that the patient return to modified duty for two weeks, then full duty.

The patient also underwent psychological counseling.

#### Requested Service(s)

Work hardening program and FCE 11-19-01 through 12-28-01

## Decision

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

## Rationale

The FCE dated 9/5/01 lists the patient's critical job demands as frequent standing, walking, occasional sitting, occasional lifting 20-30 lbs., frequent carrying 3lbs. 20 feet, occasional pulling 15 lbs., constant squatting occasional kneeling, constant bending and stooping. The FCE dated 11/16/01 indicated that at that time the patient demonstrated she could occasionally lift 30 lbs. Both from floor to waist and 15 in. to waist, could carry 40 lbs. Occasionally 100 ft. x 1 and six ft. x 10. She demonstrated frequent ability for squatting, occasional ability for bending, and constant ability for walking and kneeling. Although some of these exercises did increase her low back pain, and there was a functional deficit for squatting, the FCE of 11/16/01 failed to demonstrate a significant deficit that would prevent the patient from returning to work per her job description.

On 9/14/01 the patient was reported as having normal cervical range of motion, improved lumbar range of motion, negative straight leg raising, normal lower extremity neurological evaluation, and normal right shoulder range of motion. The patient had just completed therapy. There was no psychological screening or other evidence of the necessity for a multi-disciplinary program beyond any physical deficits. Further physical therapy could have addressed any weakness or low endurance the patient might have had.

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,