

MDR Tracking Number: M5-02-2457-01

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 program was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the 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 11-21-01 through 1-4-02 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.

**IRO Certificate #4599**

### **NOTICE OF INDEPENDENT REVIEW DECISION**

August 22, 2002

**Re: IRO Case # M5-02-2457-01**

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 51-year-old female who works as a clerical staff assistant, and who injured her back on \_\_\_ when the handle on a heavy box which she was trying to lift broke. The patient later felt pain in her back and was diagnosed with Lumbar Strain. She had four weeks of Physical therapy. An FCE, including psychological screening and vocational assessment was contacted 11/19/01, and a work hardening program was recommended. The patient was diagnosed with mild to moderate Depressive Disorder. From 11/21/01 through 1/4/02 the patient participated in the work hardening program, which included physical therapy, nutrition classes, vocational classes, pain education classes and psychological counseling.

#### Requested Service(s)

Work hardening program and 11-21-01 through 1/4/02

#### Decision

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

#### Rationale

The physical capabilities needed for the patient to perform in her job, as described in a 9/12/01 letter from her employer included lifting and carrying a maximum weight of 25 lbs., walking 5%-10%, bending and leaning over 0%-5%, stooping and crouching 0%-5%, pushing and pulling 5%-10%. The employer stated that her job duties could be modified if any tasks fell outside of the patient's capabilities. The FCE dated 11/19/01 describes the patient's occupation as in the light work level, with fair endurance. Under functional limitations, the patient's strength was described as limited to 20-25lbs. Lifting, carrying pushing and pulling. Sitting tolerance was noted as 30 hours. The patient tolerated 30 minutes of walking on a treadmill.

The patient's functional level of performance demonstrated in the FCE falls within the physical capability for her job. The patient could have been returned to work prior to the work hardening program, even at modified duty progressing to full duty, while continuing physical therapy to address any range of motion or endurance deficits.

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,