

MDR Tracking Number: M5-02-2518-01

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 rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the rendered was the only fee involved in the medical dispute to be resolved. As the treatment, work hardening program, was not found to be medically necessary, reimbursement for dates of service 4/2/01 through 4/17/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of 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, 8/5/02.

**IRO Certificate #4599**

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

July 26, 2002

**Re: IRO Case # M5-02-2518-01**

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 44-year-old male injured on \_\_\_ when he walked into a pipe while carrying cement blocks. He was diagnosed with chest contusion, thoracic pain/sprain, and post traumatic costal chondritis. X-rays were normal, and an MRI was basically normal, with a 1cm hemangioma identified. A functional capacity evaluation 3/9/01 indicated that the patient performed at the medium work level.

Requested Service

Work Hardening Program

Decision

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

Rationale

The patient was treated with extensive chiropractic manipulation and passive modalities. No documentation was provided, however, of active physical therapy. The patient was given a good prognosis for recovery based on examination. There is no documentation of the need for a multi-disciplinary program including psychiatric and vocational counseling.

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,