

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for date of service 6/7/01, but the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity was the only issue to be resolved. The Function Capacity Evaluation (FCE) on 6/7/01 was found to be medically necessary, the work hardening and other FCE were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the FCE charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 6/7/01 through 7/23/01 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 7th day of, January 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

October 9, 2003

Re: Medical Dispute Resolution
MDR #: M5.02.2741.01
IRO Certificate No.: IRO 5055

Dear:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation.

The physician reviewer **PARTIALLY AGREES** with the determination of the insurance carrier in this case. The reviewer is of the opinion that the functional capacity evaluation of 06.07.01 **WAS MEDICALLY NECESSARY**. The FCE on 07.23.01 and the work hardening program from 06.11.01 through 07.20.01 **WAS NOT MEDICALLY NECESSARY**.

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 MDR #M5-02-2741-01, in the area of Physical Medicine and Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical records from ____.
2. Medical records from ____ consisting of operative report.
3. Medical records from ____ consisting of impairment rating awarding 9% whole-person impairment.
4. Operative report of 12/07/01 indicating an amputation of the distal third and fourth fingers at the DIP joint.
5. Functional Capacity Evaluation, dated 6/07/01.
6. Work hardening records.
7. Functional Capacity Evaluation, dated 7/23/01.

B. BRIEF CLINICAL HISTORY:

This is a 36-year-old claimant who evidently was operating machinery when a saw amputated the distal third and fourth fingers of his left hand. He was seen urgently at ____ where an amputation above the DIP joint was performed by _____. Postoperatively, he attended extensive physical therapy.

He went for a contracture release of the amputated stump of the right middle finger and excision of a possible neuroma and fibroma on 4/04/01 by _____.

He continued with physical therapy and underwent a Functional Capacity Evaluation on 6/07/01 which indicated he was in the light/medium work capacity. He then proceeded to a multi-disciplinary work hardening program, and at the end of this program he received another functional capacity evaluation on 7/23/01 which indicated he was in the medium capacity.

C. DISPUTED SERVICES:

FCE on 6/07/01 and 7/23/01, and work hardening from 6/11/01 through 7/20/01.

D. DECISION:

I PARTIALLY AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

More specifically, I agree with the Functional Capacity Evaluation of 6/07/01 which indicates that the claimant was able to perform within the light/medium category for work. There is no clinical indication for the medical necessity for a multi-disciplinary approach for a work hardening program or for the FCE on 7/23/01.

E. RATIONALE OR BASIS FOR DECISION:

After review of the medical information in this case, I do not feel that a work hardening program was clinically indicated. As per the *Medical Fee Guidelines*, page 37, Subparagraph E: "Work hardening is a highly structured, goal-oriented, individualized treatment program designed to maximize the ability of the person served to return to work. These activities are used to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic, behavioral, attitudinal and vocational functioning of the person served."

It is clear that this gentleman sustained a rather severe injury to his right hand which consisted of a partial amputation of his third and fourth fingers at the DIP joint. While it is apparent that he has a whole-person impairment, this is not a compensable component of his rehabilitation. It is highly unlikely a 36-year-old gentleman became so deconditioned after a six-month period that he required a work hardening program which consisted of daily exercises and behavioral, attitudinal and vocational rehabilitation.

Therefore, I agree that a work hardening program was neither reasonable nor medically necessary.

F. 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.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 4 October 2002