

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 respondent prevailed** on the issues of medical necessity. Therefore in accordance with §133.308(q)(9), the Commission hereby **Declines to Order** the respondent to reimburse the **requestor** for the paid IRO fee.

According to the IRO, the disputed work hardening program from 5/1/01 through 6/18/01 **was not medically necessary**. 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 work hardening program was found to **not** be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

This Decision is applicable to dates of service 5/1/01 through 6/18/01 in this dispute.

This Decision is hereby issued this 19th day of November 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

October 8, 2002

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR#: M5-02-2764-01
IRO Certificate No.: IRO

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. A physician who is Board Certified in Physical Medicine and Rehabilitation reviewed your case.

The physician reviewer **AGREES** with the determination of the insurance carrier in this case. The reviewer is of the opinion that the work hardening program administered from 05.01.01 through 06.18.01 **WAS NOT MEDICALLY NECESSARY.**

I am the Secretary and General Counsel of ____ 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 #M5-02-2764-01, in the area of Physical Medicine and Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Initial note and progress notes from _____.
2. Initial Medical Reports from _____.
3. Impairment Rating by _____ with whole-person impairment of 6%.
4. Medical records from _____.
5. Medical records from _____, noting a request for a spinal cord stimulator.
6. Psychological evaluation by _____.
7. Psychological evaluation by _____.
8. Extensive physical therapy records.
9. Functional Capacity Evaluation, dated 6/11/02, noting the claimant to be in a light work capacity.
10. Work hardening records.
11. MRI of the lumbar spine, dated 10/18/00, noting early disk degeneration at L4-5 and L5-S1 without evidence of disk herniation or spinal stenosis.
12. Results of a diskogram, suggesting that the bottom three disks of the lumbar spine do not contribute to his symptoms.

B. BRIEF CLINICAL HISTORY:

This claimant is a 33-year-old gentleman who apparently injured his back, neck, and shoulder while employed at _____. Evidently, he was pulling on a trailer at work on _____ when the trailer gave way, and he had the sudden onset of neck pain and left upper extremity pain, along with lumbar pain. Since that time, he has undergone extensive physical therapy and multiple injections. He underwent a surgical consultation and was not considered a surgical candidate.

He has persisted with complaints of lumbar spine radiculopathy. He has attended an extensive work hardening program and has recently been evaluated by _____ who feels he is a candidate for a spinal cord stimulator.

He received an Impairment Rating by _____, awarding a 6% whole-person impairment. Of note were the positive Waddell signs.

C. DISPUTED SERVICES:

The work hardening program that was initiated on 5/01/01 through 6/18/01.

D. DECISION:

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

E. RATIONALE OR BASIS FOR DECISION:

After review of the medical information provided to include the mechanism of injury and the clinical and diagnostic findings, it is apparent that this gentleman has a rather minor degenerative condition involving his lumbar spine. This may indeed have been aggravated by the compensable injury. The treatment to date has been conservative in nature, consisting of physical therapy, multiple injections, and medications, all of which have yielded little or no benefit. It is not reasonable to assume after this length of time that a work hardening program would prove to be beneficial. There is evidence of chronic pain behavior, as documented by _____ that the claimant appears to be unwilling to resume any type of gainful employment. Therefore, based on the medical records provided, I believe the work hardening program that was requested and performed did not yield benefits that one might expect from a work hardening program.

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: 7 October 2002