

MDR Tracking Number: M5-02-2785-01

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 and functional capacity evaluation (FCE) rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that work hardening and FCE fees were the only fees involved in the medical dispute to be resolved. As the treatment, (work hardening and FCE) was not found to be medically necessary, reimbursement for dates of service from 6/26/01 through 7/31/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 30th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

Enclosure: IRO decision

October 18, 2002

Re: Medical Dispute Resolution
MDR #: M5.02.2785.01
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. This case was reviewed by a physician who is certified in Chiropractic medicine.

Clinical History:

The patient was injured when he slipped and fell in a walk-in freezer on _____. The patient fell on his left arm. The patient was initially treated by an M.D. and transferred care to a Chiropractor on 5/18/01. The patient had an NCV performed on 6/02/01 and a Functional Capacity Evaluation performed on 6/18/01. Work hardening services were initiated on 6/25/01 and ran through 7/31/01.

Disputed Services:

Denial of Work Hardening for 6/25/01-07/31/01, and functional capacity evaluation on 7/31/01.

Decision:

The reviewer agrees with the determination of the insurance carrier that the work hardening program from 6/26/01-7/31/01 and the functional capacity evaluation on 7/31/01 were not medically necessary.

Rationale:

In the reviewer's opinion the patient's records show no reference from a multi-disciplinary treatment standpoint for the necessity of work hardening services. The patient's diagnosis of medial condylitis does not warrant such an extensive course of treatment.

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.

Sincerely,