

MDR Tracking Number: M5-02-2928-01

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 office visit and work hardening rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that office visit and work hardening fees were the only fees involved in the medical dispute to be resolved. As the treatment, (office visit and work hardening program) was not found to be medically necessary, reimbursement for dates of service from 12/18/01 through 1/31/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1st day of, November 2002.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

**IRO Certificate #4599**

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

October 28, 2002

**Re: IRO Case # M5-02-2928-01**

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 IROs, 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, based on the records provided for review, the following:

#### History

The patient is a 46-year-old female who injured her right shoulder in \_\_\_\_. Differing dates are reported as the date of injury. The patient apparently was initially treated conservatively. An MRI 3/12/01 showed a distal right clavicle fracture. Surgery was performed on 5/14/01 including open reduction and internal fixation of right distal clavicle nonunion and iliac crest bone graft, and a second surgery was performed on 6/20/01 consisting of distal clavisectomy and removal of symptomatic hardware from the right distal clavicle. The patient was treated with physical therapy for passive and active range of motion. An FCE on 12/20/01 found decreased grip strength on the right, normal range of motion in the right shoulder, and some weakness in lifting tasks. Overall the patient was reported as functioning at a light physical demand level. It is not stated, but it is assumed that the patient's job required a greater physical demand level than she demonstrated.

#### Requested Service(s)

Work Hardening Program

#### Decision

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

#### Rationale

THE FCE on 12/20/01 documented strength deficits demonstrated by the patient. It did not document any deficits that would require a multi disciplinary approach to her therapy. No psychological or vocational testing or screening that might show a need for the work hardening program was provided for review. The patient probably would have benefited from continued strengthening and conditioning in her shoulder. But this did not appear to require a multi disciplinary approach.

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,