

MDR Tracking Numer: M5-02-2938-01

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 work hardening was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that work hardening fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 7/16/01 to 7/20/01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6th day of December 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

Fax 512/218-1395

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 12, 2002

Re: IRO Case # M5-02-2938

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 Doctor of Chiropractic who is licensed by the State of Texas and who is a Certified Strength and Conditioning Specialist. 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

The patient was injured in ___ when she slipped and fell on an oily floor. She landed on her tailbone and right elbow. She received therapy, chiropractic care and injections. Her MRI, X-rays and EMG were essentially normal.

Requested Service(s)

Work hardening Program 7/16/02 – 7/20/01

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient received extensive therapy and rehabilitation for several months prior to the start of the work hardening with little, if any, positive results. Myofascial pain syndromes should respond very well to properly administered spinal manipulation, McKenzie exercises and PNF stretching and conditioning. The patient received months of treatments with poor results. If the treatment were properly administered, it is highly probable that the patient would have responded very well, and treatment time and expense would have been reduced.

It appears that the work hardening program in dispute was initiated because treatment failed. The work hardening program was neither cost effective nor in the best interest of the patient. Documentation presented for treatment after the disputed dates of service shows that the work

hardening program also failed. It is documented on 7/20/01 that “her pain level was rated at an average of 5-8 out of 10 on a 1-10 point scale.” This is after several months of treatment and one week of work hardening. On 10/12/01 it is documented that the patient continues to have the same initial complaints of low back pain and that “Discomfort continues throughout the day and night.”

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,