

MDR Tracking Number: M5-02-2970-01

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 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. Therefore, upon receipt of this Order and in accordance with §133.308(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for 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 FCE (function capacity evaluation) was found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the FCE.

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 date of service 1/8/02 in this dispute and IRO fee.

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 22nd day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

October 18, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 02 2970 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient on this case was injured on his job in ___ when he had a laceration to the left 5th (little) finger. Initially he was treated at an emergency room with a surgical repair of the laceration by the ER doctor. He began treatment shortly after by ___, who is the treating doctor on this case. The carrier's agent, ___, requested and received authorization for a Required Medical Examination by ___. ___ attended the patient at his office on January 3, 2002. The RME records indicate that the patient was referred to ___ for a Functional Capacity Evaluation. A statement by the president of ___, indicates that the requestor did contact the carrier's adjuster, ___. He states that ___ approved the FCE "reasonable and necessary". The records also include a referral from ___ dated 1-2-2002 for the FCE referral. The FCE was utilized by ___ in his RME report to indicate that the patient could perform 8 hours per day of light duty.

DISPUTED SERVICES

Functional Capacity Evaluation

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The FCE was a measure of the patient's status and ability to perform work following a work-related injury. The carrier's own RME doctor referred for the evaluation and utilized the findings in his report. The FCE was clearly performed within the highest standards for such an injury as suffered by this patient. The service performed also demonstrated limitations by this patient which a reasonable person would find to be significant before returning such a patient to a working environment which could require heavy levels of work. This testing was clearly reasonable and certainly necessary to the assessment of a patient's condition, especially considering that it was referred by the carrier's own RME doctor to assess return to work issues at the request of the carrier.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,