

MDR Tracking Number: M5-04-1724-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on February 10, 2004.

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 and Functional Capacity were 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 fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 06-16-03 to 07-03-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 26th day of May 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

May 20, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Letter**

RE: MDR Tracking #: M5-04-1724-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in occupational medicine. The ___

physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ____. The patient reported that while at work she slipped and fell injuring her back. The diagnoses for this patient have included lumbar sprain/strain and shoulder sprain/strain, cervical sprain/strain, and cervical and lumbar disc protrusion. A MRI of the cervical, lumbar spine and left shoulder dated 5/14/03 indicated a 2mm posterior central disc protrusion at L4-L5, C5-C6, C7-T1, a 4mm at C6-C7, mild degenerative hypertrophy at the left AC joint causing mild anterior shoulder outlet stenosis, mild distal supraspinatus tendonitis, and joint effusion. The patient was initially treated with therapy followed by a work hardening program.

Requested Services

Work Hardening and Functional Capacity, per hour from 6/16/03 through 7/3/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her back on ____. The ___ physician reviewer indicated that the patient had been treated for several levels of mild herniations in the cervical and lumbar region. The ___ physician reviewer also indicated that at the C6-7 level there was some impingement upon the thecal sac and annular tears were noted in the L4-5 and L5-S1 levels. The ___ physician reviewer noted that the patient entered a work hardening program approximately 4 weeks after the work related injury to restore function to a medium work level. The ___ physician reviewer explained that patients with neck, shoulder, back and other musculoskeletal complaints resolve spontaneously, or with conservative treatment within 4-6 weeks after the initial injury date. The ___ physician reviewer also explained that most MRI studies and more aggressive management of musculoskeletal complaints, such as work hardening or conditioning, occur after this 4-6 week period has been exhausted without resolution (Cochrane Database Syst. Rev. 2003 (1): CD001822, Work 2001; 165(3): 235-43, Work 2000; 15(1): 21-23, Spine 2000 Nov 1; 25(19): 2494-500). Therefore, the ___ physician consultant concluded that the Work Hardening and Functional Capacity per hour from 6/16/03 through 7/3/03 were not medically necessary to treat this patient's condition.

Sincerely,