

MDR Tracking Number: M5-04-2592-01

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 4-20-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of Functional Capacity Evaluation. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

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 Functional Capacity Evaluation was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above services.

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 01-23-04 in this dispute.

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 Decision and Order is hereby issued this 2nd day of August 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

August 2, 2004

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

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___ 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 chiropractor on the ___ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 ___ chiropractor 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 fell from a chair injuring her cervical, thoracic and lumbar spines as well as her left shoulder. The treating diagnoses for this patient have included sprain of unspecified site of shoulder and upper arm, neck sprain, lumbar sprain, and pain in the thoracic spine. The patient underwent a functional capacity exam on 1/23/04 to determine her functional ability for work release.

Requested Services

Functional Capacity Exam on 1/23/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Treating Doctor Position Statement for IRO 1/1/04
2. FCE 1/23/04

Documents Submitted by Respondent:

1. Peer review 10/9/02
2. Medical record review 12/9/02
3. Required medical exam 12/22/03

Decision

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

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her cervical, thoracic, and lumbar spines and left shoulder on ____. The ___ chiropractor reviewer indicated that the patient falls within the tertiary phase of care (National Spine Society Guidelines for multidisciplinary spine care specialists). The ___ chiropractor reviewer noted that this patient had completed a chronic pain program on 1/16/04 and underwent a functional capacity evaluation on 1/23/04. The ___ chiropractor reviewer explained that one of the assessment protocols for a patient in the tertiary phase of care is to perform an functional capacity evaluation of the whole body performance.

The ___ chiropractor reviewer also explained that the functional capacity evaluation this patient underwent was to determine her return to work restrictions. Therefore, the ___ chiropractor consultant concluded that the functional capacity evaluation performed on 1/23/04 was medically necessary to treat this patient's condition.

Sincerely,