

MDR Tracking Number: M5-04-2867-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-03-04.

The IRO reviewed work hardening and work hardening each additional hour, FCE and therapeutic exercises rendered from 08-29-03 through 11-11-03 that were denied based upon "V". The IRO concluded that work hardening, work hardening each additional hour and FCE **were** medically necessary for dates of service 08-29-03 through 11-11-03. The IRO concluded that therapeutic exercises **were not** medically necessary for dates of service 08-29-03 through 11-11-03.

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees. 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.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This Findings and Decision is hereby issued this 17<sup>th</sup> day of August 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for dates of service 08-29-03 through 11-11-03 in this dispute.

This Order is hereby issued this 17<sup>th</sup> day of August 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

August 6, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

**REVISED REPORT**  
**Corrected disputed services and a portion of the decision.**

Re: Medical Dispute Resolution  
MDR #: M5-04-2867-01  
TWCC#: \_\_\_\_\_  
Injured Employee: \_\_\_\_\_  
DOI: \_\_\_\_\_  
SS#: \_\_\_\_\_  
IRO Certificate No.: 5055

Dear \_\_\_\_\_

\_\_\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_\_\_ viewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

**REVIEWER'S REPORT**

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's  
Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, FCE, nerve conduction study and radiology reports.  
Information provided by Respondent: correspondence and designated doctor exam.

**Clinical History:**

This a patient felt a sharp pain in her low back following a work injury on \_\_\_\_\_. Originally, she received treatment, medication, and then afterwards was referred for

chiropractic treatment. MRI on 06/18/03 revealed no damage to the neuro structure or discs, thus indicating no physical injury from her history.

**Disputed Services:**

Therapeutic exercises, work hardening, work hardening-each additional hour, and FCE from 08/29/03 thru 11/11/03.

**Decision:**

The reviewer partially agrees with the determination of the insurance carrier as follows:

- Work hardening and work hardening-each additional hour was medically necessary – 08/29/03 thru 11/11/03.
- FCE were medically necessary – 08/29/03 thru 11/11/03.
- Therapeutic exercises were not medically necessary – 08/29/03 thru 11/11/03

**Rationale:**

After reviewing the designated doctor report, the addendum to his report, the peer review doctor's opinion, and given the nature of the injury, the mechanism of injury, and the findings from the 06/18/03 MRI, this patient is entitled to adequate medical care given the underlying history of her diabetes.

The work hardening and work hardening-each additional hour and FCE, were valid as far as the entitlement of this patient's treatment given the mechanism of injury. However, the therapeutic exercises were of no use at the time due to the MRI results. The patient should have been sent over to the rehab facility for an evaluation and treatment. The provider followed the proper protocol as far as work hardening. Any therapeutic exercises that were done prior to the MRI were adequate. Once the revelation of the MRI was known, then the patient should have been referred to rehab at that point.

Sincerely,