

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. The dispute was received on 08-05-04.

The Medical Review 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 (initial and additional hours) and functional capacity evaluation 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 08-14-03 to 09-11-03 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 4th day of January 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

**IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter**

Date: December 30, 2004 (Revised)
Injured Employee:
MDR #: M5-04-4140-01
WCC #:
MCMC Certification #: 5294

Requested Services: Dates of service 08/14/2003-09/11/2003. Work hardening (initial and additional hours) –97545 & 97546, functional capacity evaluation (97750-FC).

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above requested services.

Please be advised that a MCMC Chiropractic Advisor has determined that your request for M5 Retrospective Medical Necessity, Medical Dispute Resolution on 11/18/2004 concerning the medical necessity of the above requested service hereby **Upholds the carrier's decision that the services are not medically necessary.** Based on:

- *Explanation of review 07/09/2003 through 09/11/2003
- *MDR request dated 08/04/2004
- *Letter of medical necessity dated 07/01/2004
- *Table of disputed services dated 08/14/2004 through 09/11/2003
- *Rehab daily notes dated 02/19/2003 through 09/11/2003
- *Final FCE dated 09/02/2003
- *Patient orientation and education checklist dated 07/25/2003
- *Status FCE dated 07/23/2003
- *Rehab re-evaluation exam dated 06/11/2003
- *Rehab re-evaluation exam dated 06/04/2003
- *Initial FCE dated 05/22/2003
- *Visual pain rating and pain program dated 05/22/2003
- *Clinical and rehabilitation psychology report dated 05/22/2003
- *Patient Orientation and education checklist dated 05/27/2003
- *Work program participant intake sheet dated 06/22/2003
- *Clinic notes dated 05/27/2003 through 08/18/2003
- *Service requests dated 05/13/2003 through 08/18/2003
- *Lone Radiology lumbar spine report dated 07/01/2003
- *Lone Radiology lumbar spine report dated 06/17/2003
- *Lone Radiology lumbar spine report dated 06/04/2003
- *Lone Radiology right ribs report dated 03/26/2003
- *Lone Radiology right rib cage report dated 03/12/2003
- *Internal Radiographic report dated 06/17/2003
- *Internal Radiographic report dated 06/05/2003
- *Letter of disputed compensability dated 05/29/2003
- *TWCC work status report dated 03/13/2003 through 05/02/2003
- *Gulf Coast Orthopedic consultation form dated 05/07/2003
- *Marlon Padilla medical consultation exam dated 04/02/2003
- *Marlon Padilla intake medical report dated 03/18/2003
- *Accident and Injury chiropractic initial report dated 03/24/2003

This injured employee suffered an unusual injury of rib fracture with no real evidence of Significant trauma. He underwent a course of physical therapy that provided relief to this claimant. By 05/07/2003, the claimant pain level was three out of 10 and had a condition described as "Self-limiting." There were no significant psychosocial factors to support a multidisciplinary work hardening program. The claimant was at a functional level sufficient that he should have been able to return to work on a modified duty basis. There is no evidence that this avenue was even addressed. Based on a thorough

review of the submitted documentation, the medical necessity for the work hardening program and functional capacity evaluations was not established. Consistent with Texas Labor Code 408.021, the claimant did sustain a compensable injury for which he received treatment. Labor Code 401.011 indicates that the health care is to include all reasonable and necessary medical services. The work hardening program and functional capacity evaluations were not considered reasonable or necessary medical services for this claimant.

The reviewing provider is a licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5)).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was via to the office of the IRO on this

____10th __ day of December 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____