MDR Tracking Number: M5-03-0098-01

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 $650.00** 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 work hardening program was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these work hardening charges.

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 dates of service 8/28/01 through 9/17/01in 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 Order is hereby issued this 16th day of December 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 9, 2002

Re: IRO Case # M5-03-0098

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is board certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

> History
> The patient is a 41-year-old female who slipped and fell backwards, twisting her knee and landing on her back, neck and shoulder. She injured her neck, back, right knee, and shoulder. Examination revealed muscle spasm tenderness and decreased range of motion in the cervical and thoracic spine. She also had decreased range of motion in her left shoulder and right knee. She was diagnosed with cervical and thoracic sprain, left shoulder sprain and right knee internal derangement. The patient received physical therapy and pain medication, but the pain continued in her leg and shoulder. MRIs of the knee, leg and shoulder were negative. The patient's low back pain improved with physical therapy and the pain resolved. The patient had continued neck pain, and she was treated with a cervical facet joint injections. An FCE in August 2001 showed the patient to be at a light to

medium physical demand level, which was below the physical demands of the patient's job. The patient was also found to have some inappropriate illness behavior. The patient was treated with a work hardening program. An FCE on 9/12/01 showed the patient to be at a medium physical demand level with inappropriate illness behavior resolved. An FCE 10/01/01 showed that the patient functioned at a medium physical demand level and was able to complete her tasks without pain.

Requested Service
Work Hardening Program 8/28/01-9/17/01

Decision
I disagree with the carrier's decision to deny the requested treatment.

Rationale
The patient suffered injuries to multiple areas of her body. Physical therapy was able to successfully treat one area. But the patient had continued pain which kept her from doing the normal activities of her physically demanding job as an RN working in patient care. She was also shown to exhibit some inappropriate illness behavior which required treatment by a psychologist. The work hardening program was necessary and appropriate, and it was successful and the patient returned to work.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,