MDR Tracking Number: M5-03-0517-01

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

This Order is hereby issued this 31st day of January 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

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 12/17/01 through 1/18/02.

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 31st day of January 2003.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division

DRM/nlb

January 6, 2003

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR#: M5-03-0517-01
IRO Certificate No.: IRO 5055

Dear:

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

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Chiropractic medicine.

Clinical History:
This is a male claimant who was injured in an automobile accident while on his job on ___.

Disputed Services:
Work hardening program from 12/17/01 through 01/18/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the program in question was medically necessary in this case.

Rationale for Decision:
Functional Capacity Evaluation testing on 12/04/01 revealed that the patient was unable to return to his former employment. In

addition, psychological testing on that date revealed issues that needed to be properly addressed.

Based on the diagnostic testing and psychological evaluation, and the *TWCC Treatment Guidelines that* were in effect at the time these services were rendered, a work hardening program was usual, customary, reasonable and medically necessary to treat this patient's on-the-job injury, and to attempt to progress him into a job classification of medium-to-heavy in order of him to safely return to work.

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 who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,