MDR Tracking Number: M5-03-0558-01

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.

This Finding and Decision is hereby issued this 27th day of May 2003.

Carol R. Lawrence
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 dates of service 2/11/02 through 3/22/02 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 Order is hereby issued this 27th day of May 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/cl

May 23, 2003

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

REVISED
Dates of Service Corrected

Re: Medical Dispute Resolution
MDR #: M5-03-0558-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ 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 Orthopedic Surgery.

Clinical History:
This 42-year-old female claimant injured her back and lower extremity on her job on ___. Lumbar spine fusion was done on 11/09/00, and a second lumbar spine procedure was done on 11/16/00, due to persistence of her lower extremity pain.

A third operation, removal of previous hardware, and spine instrumentation and fusion was done 07/16/01, for pseudarthrosis

of the previous fusion at L4-L5 and L5-S1. The patient was also treated with pain medication and physical therapy, and was provided the apparatus and incentive for home exercise. She had a supervised weight reduction trial, Functional Capacity Evaluation, a work hardening program, chronic pain assessment and attempted management. She also underwent psychiatric evaluation with recommendations to be incorporated into her pain management program.

Disputed Services:
Work hardening and FCE from 02/11/02 through 03/22/02.

Decision:
The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the work hardening program and FCE during the period indicated were medically necessary in this case.

Rationale for Decision:
Obviously, medical, psychological and behavioral explanations exist for this patient's chronic pain, depression and failure to return to work. All reasonable attempts to rehabilitate her for gainful employment were largely unsuccessful. Nonetheless, it was appropriate to evaluate her capacity for work, and to give her the benefit of a one-month effort in a work hardening program, 02/11/02 through 03/22/02.

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.

Sincerely,