

MDR Tracking Number: M5-03-1603-01

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 (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 2/26/03.

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(r)(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 and functional capacity evaluations **were** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for work hardening and functional capacity evaluations.

This Finding and Decision is hereby issued this 26th day of August 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 3/14/02 through 4/10/02 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 26th day of August 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/crl

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IRO Certificate# 5259

August 11, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

CLINICAL HISTORY

The records have been reviewed and they indicate that this is a 40-year old female who complains of right shoulder, right knee, and low back pain as a result of a work-related injury of _____. She apparently reported injury occurring after tripping over a box, causing her to fall to a wall, hurting her back, shoulder, and knee. Workup included evaluation by _____ and a second opinion by _____, an orthopedic surgeon, as well as an MRI of the knee showing ACL rupture and mensical tears. The patient had treatment with Synvisc injections to the knee, as well as physical therapy for the knee and back, and a work hardening program with an ultimate impairment rating provided by _____.

REQUESTED SERVICE (S)

The services in dispute are work hardening treatment at _____ for four weeks, and functional capacity evaluations from the dates of 3/14/02 through 4/10/02.

DECISION

Approve work hardening treatment and functional capacity evaluations.

RATIONALE/BASIS FOR DECISION

The records reviewed indicate a fairly typical course of treatment for an individual who had an obvious work-related trip and fall with severe injury to the right knee with an ACL tear that did not proceed with surgery and an obese, short-stature female who had severe back pain, knee pain, and shoulder pain. She received appropriate physical therapy and subsequently participated in four weeks of work hardening. She was seen by _____ for maximum medical improvement, and all the records reviewed, including the treating physician records, the consultation physician records by _____, the orthopedic

surgeon, and the consultation with ___ for impairment, are consistent with the standards and norms of general practice in the state of Texas for provision of work hardening post-injury with back injury and ACL injury. There is no evidence to contradict the necessity of a work hardening program as a final step in treatment after sustaining a fall with back injury, knee injury, and ACL rupture.