MDR Tracking Number: M5-03-2007-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-15-03.

The IRO reviewed functional capacity evaluation (FCE), work hardening program, team conference with physician, office visits, and office visit with manipulations rendered from 12-17-02 through 01-27-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for work hardening program, team conference with physician, office visits, and office visit with manipulations. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issue of medical necessity for the functional capacity evaluation (FCE).

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 not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 10, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Per Rule 126.9 (h)(2) a Benefit Contested Case Hearing was held on October 8, 2003 and a decision was made that the claimant is not entitled to change treating doctors. Therefore we are unable to review disputed services for dates of service 12-26-02, 01-06-03, 01-16-03 and 01-21-03 denied "K" for not appropriate Healthcare provider or "L" not treating doctor approved treatment.

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for date of service 12-20-02 in this dispute.

This Order is hereby issued this 5th day of January 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

July 1, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-2007-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating 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 the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient was injured on ___ while working as an electrician. He was carrying a trash bag when it slipped and he caught it, causing him to hurt his back. A lumbar MRI revealed disc bulging at L4-5 and L5-S1 and electromyography (EMG) showed a sensory loss at the right L5-S1 nerve root.

Requested Service(s)
Work hardening program, team conference with physician, office visit, office visit with manipulation, and functional capacity evaluation from 12/17/02 through 01/27/03

Decision
It is determined that the functional capacity evaluation (FCE) on 12/20/02 was necessary to treat this patient's condition. However, it is determined that the work hardening program, team conference with physician, office visit, office visit with manipulation from 12/17/02 through 01/27/03 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The functional capacity evaluations (FCE) that were performed form 06/11/02 through 12/20/02 show that the patient remains unable to return to his pre-injury physical demands level.

A six week course of work hardening was appropriate to treat this patient's medical condition; however, the necessity for an additional two week course in the program is not evident from the enclosed medical record.

Additional trials of work hardening applications are not warranted due to the lack of functional progress toward program defined goals like increased physical demands capabilities. It is doubtful that the patient would have actually made the functional progress necessary to return to medium physical demands capabilities in the purposed trial of these therapies.

Any further implementation of unidisciplinary treatment applications used to treat the patient's medical condition are not appropriate. The patient must continue to be transitioned to active patient-driven therapeutics that should include a supervised home rehabilitation program with periodic clinical monitoring. The continued upper level therapeutics purposed by the provider have been exhausted; regression to lower level therapeutics is not warranted.

The forwarded medical record shows that the patient was placed at maximum medical improvement (MMI) on 03/27/03. This would be an accurate and fair assessment of the patient's current functional status.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- *Adult Low Back Pain.* Institute for Clinical Systems improvement; 2001, May. 50p.

- *Unremitting low back pain. In: North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists.* North American Spine Society (NASS); 2000. 96p.

Sincerely,