MDR Tracking Number: M5-03-2637-01

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 June 17, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening program and the Functional Capacity Evaluation were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the work hardening program and the Functional Capacity Evaluation were not found to be medically necessary, reimbursement for dates of service from 10/21/02 through 12/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of October 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

October 17, 2003

Re: MDR #: M5-03-2637-01
IRO Certificate No.: IRO 5055

REVISED REPORT
Added FCE on 10/21/02

___ 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 certified in Physical Medicine and Rehabilitation.

Clinical History:
This female patient injured her right upper extremity, right shoulder and neck in an on-the-job accident on ___. She was treated with medications, physical therapy, and activity modification, as well as cervical ESI's which were of no significant lasting benefit. Subacromial right shoulder injection was also administered without significant improvement.

Disputed Services:
Work hardening program from 10/21/02 through 12/12/02, and FCE on 10/21/02.

Decision:
The reviewer agrees with the determination of the insurance carrier. The work hardening program was not medically necessary.

Rationale:
On the initial evaluation, the patient's pain level was 9/10, which would not predict success in an activity-based program. On 11/07/02, a positive Finkelstein's test was observed and reported. A de Quervain's tendonitis would not be likely to improve with work hardening and would, in fact, most likely worsen, thereby contraindicating the continued treatment until and if that pain syndrome became resolved or stabilized. Additionally, the development of a positive impingement test at the right shoulder, indicating rotator cuff tendonitis, during the program was similarly unlikely to improve. After the third week of the program, the patient reported no improvement.

Because the Work Hardening Program was not indicated, the FCE performed on 10/21/02 was likewise not indicated.

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,