MDR Tracking Number: M5-03-3255-01

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. The dispute was received on 8-11-03.

The Medical Review 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 FCE, work hardening program, and unlisted evaluation and management service 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 Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 9-26-02 to 11-18-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of January 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-3255-01

September 3, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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
Patient fell at work on ___ sustaining injury to her cervical, thoracic and lumbar spine.

REQUESTED SERVICE(S)
Work hardening, functional capacity evaluation, unlisted evaluation and management service from 9/26/02 through 11/7/02, 11/8/02 and 11/18/02.

DECISION
Deny.

RATIONALE/BASIS FOR DECISION
The medical records fail to document the medial necessity for any of the treatments performed on the dates in question.

The physician's 'initial report' dated 5/22/02 listed a multitude of diagnoses. Subsequent evaluations and examinations by other providers failed to offer any material substantiation for the physician's diagnoses. For example, this patient was initially and finally diagnosed with 'Lumbar disc displacement' (722.1). However, the lumbar spine MRI on 5/20/02 was negative for disc bulge or herniation and the lumbar x-rays taken on 5/14/02 showed the intervertebral disc spaces were normal.

Initial cervical and lumbar ranges of motion were near normal, thus failing to offer sufficient substantiation for the diagnoses rendered and the treatments performed.

Under II, E., 1., b. of the TWCC Medical Fee Guideline, criteria for admission to a work hardening program includes, 'persons whose current levels of functioning due to illness or injury interfere with their ability to carry out specific tasks required in the workplace.' Although the physician's 'initial report' states that the patient is required to 'lift 50+ lbs.' there is no support in the records to document that statement. In fact, the patient stated (loosely translated from Spanish on page 304) that her job consists of making sure everything is in its place, preparing people to work and coordinating and making sure everything is clean. The non-strenuous nature of her job is also confirmed by her notation (page 328) that 67-100% of her work for 6-8 hours per day is walking. Therefore, there is no documentation to support the medical necessity of a work hardening program for this patient.

Under II, E., 8. of the TWCC Medial Fee Guideline, it states, 'Daily treatment and patient response to treatment shall be documented and reviewed to ensure continued progress.' In this patient's case, 'continued progress' was most certainly not documented since progress did not occur. The patient remained completely disabled (11/8/02 Neck Disability Index), regressed from 'severe' (8/30/02 Oswestry) to 'crippled' (11/8/02 Oswestry), and had decreased lumbar ROM in all planes (page 290) after the work hardening was completed.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.