

April 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0716-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in occupational medicine, preventative medicine and public health. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old male who sustained a work related injury on ___. The patient reported that while at work he was lifting a desk when he injured his left shoulder. The diagnoses for this patient include left shoulder glenoid labral tear, biceps avulsion and recurrent imping. The patient has been treated with shoulder acromioplasty with glenoid labral repair on 2/6/02. He was then treated with physical therapy, psychotherapy and medications. The patient also completed a 6 week work conditioning program followed by 3 weeks of work hardening.

Requested Services

Work Hardening times 5 additional weeks.

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient was treated with shoulder surgery, physical therapy post surgery, psychotherapy, medications, and a work conditioning program followed by three weeks of work hardening. The ___ physician reviewer indicated that the patient appears to have achieved good benefit from his work hardening program. The ___ physician reviewer

explained that the patient has achieved good lifting, pushing and pulling tolerances. The ___ physician reviewer explained that a work hardening program has no pre-defined length of treatment. However, the ___ physician reviewer also explained that 3-4 weeks is the average treatment period for a work hardening program. (Work 2001; 16(3): 235-43. Work 2000; 15(1): 21-23. Cochrane Database Syst. Rev. 2003 (1): CD001822. Clinic J Pain 2001 Dec; 17(4 Suppl): S128-32.) Therefore, the ___ physician consultant concluded that one additional week of work hardening is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

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)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

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)** 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. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 23rd day of April 2003.