

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 30, 2003

RE: MDR Tracking #: M2-03-1759-01
IRO Certificate #: 5242

___ 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 proposed 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 Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer 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

According to the supplied documentation, it appears that the claimant was working on a ladder on ___ when he fell off, sustaining injuries to his lower back, left leg and right hand. The claimant began care with ___ and was treated with chiropractic modalities. A report from ___ dated 04/21/2003 revealed that the claimant had a non-displaced basal fracture of his middle phalanx. Plain film x-rays were taken on 05/19/2003 and revealed a normal appearance of his right hand. Chiropractic therapy continued. The claimant had a functional capacity exam performed on 07/24/2003 that revealed that the claimant could lift between 20-30lbs and was at a moderate work level. The documentation ends with a letter from the treating doctor requesting 8 weeks of work hardening.

Requested Service(s)

Please review and address the medical necessity of a work hardening program lasting for 8 weeks for the referenced injured worker.

Decision

I agree with the insurance company that the services requested are not medically necessary.

Rationale/Basis for Decision

The documentation presented for review revealed that the claimant has made a significant improvement in his relatively short recovery time. The functional capacity exam report stated that the claimant was at a moderate work level. Since the claimant is able to work at a moderate level, it would not support a work hardening program at this time. The functional capacity exam report does support the claimant returning to the work force at a limited capacity while he could continue a home exercise program and would allow for his injuries to heal. Current medical protocol does not support a work hardening program for this claimant without further objective documentation showing that his deficiencies would not be corrected without the proposed work hardening program. Since the supplied documentation did not support this and current guidelines do not support it, it is not considered medically reasonable or medically necessary.

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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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)).

This decision by the IRO is deemed to be a TWCC decision and order.