

February 13, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0427-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. 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 35 year-old male who sustained a work related injury ____. The patient reported that while at work he injured his back and sustained a right inguinal hernia. On 4/26/03 the patient underwent an MRI that showed disc herniation of the L3-L4, L4-L5, and L5-S1. On 4/21/03, an EMG of the lower extremities indicated L5 radiculopathy. The diagnoses for this patient have included lumbosacral sprain/strain, inguinal hernia, sprain/strain of wrist, and lumbar radiculitis. Treatment for this patient's condition has included epidural steroid injections, medications and physical therapy. The patient has also undergone an inguinal hernia repair on 3/24/03.

Requested Services

Work Hardening Program 5 times a week for 6 weeks.

Decision

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

Rationale/Basis for Decision

The physician reviewer noted that this case concerns a 35 year-old male who sustained a work related injury to his back on ____. The physician reviewer indicated that the patient has low back pain, left lower extremity radiculopathy, MRI positive for disc herniation, and EMG positive for L5 radiculopathy. The physician reviewer noted that the patient received a series of three epidural steroid injections. The physician reviewer also noted that on 8/12/03 the patient underwent a functional capacity exam and was found to be at light physical demand level.

However, the physician reviewer explained that it was noted that the patient experienced difficulty with performing some of the tasks during the functional capacity exam. The physician reviewer also explained that a physical therapy note dated 8/11/03 rated the patient's pain level as the best being a 7/10 and the worst pain being a 9/10. The physician reviewer indicated that the patient was noted to be experiencing continued difficulties with activities of daily living due to pain. The physician reviewer explained that the last documented pain level available was on 8/11/03 as a 7-9/10. The physician reviewer also explained that this patient is not ready for a work hardening program with pain levels rated at 7-9/10. Therefore, the physician consultant concluded that the requested work hardening program 5 times a week for 6 weeks is not 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 13th day of February 2004.