NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 15, 2004

RE: MDR Tracking #: M2-04-0583-01
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 injured her low back, left knee, neck and shoulder when she was injured in a motor vehicle accident while working on ___. The patient reported to the emergency room 2 weeks later and was told to seek further care. The claimant reported to ___ for evaluation and treatment. The claimant underwent various diagnostic testing. The claimant's treatment began with chiropractic therapy. The claimant had epidural steroid injections performed in her cervical, lumbar and pelvic regions. The claimant underwent surgeries in her left wrist in 10/02 and in her neck in 02/02. The claimant went through a pain management program and her treating doctor feels that a work hardening program would benefit her.

Requested Service(s)
Please review and address the medical necessity of the services including work hardening 5 times a week for 6 weeks.

Decision
I agree with the insurance company that the requested work hardening program is not medically necessary.

Rationale/Basis for Decision
The attached documentation supports that the claimant has underwent a plethora of medical treatment in the last approximate 3 years. The documentation supplied does not adequately support a work hardening program. With the amount of intense therapy that the claimant has received, it appears that exercises or a home-based exercise program would assist the claimant in returning to a pre-injury condition. The documentation states on several occasions that the claimant is eager to return to work and motivated. With that being the case, then a home-based exercise program should assist help return her to prior physical level. There was no indication that the work hardening program would benefit the claimant anymore than she could do on her own. Since the claimant has been through a pain management program, she should be able to perform enough activity to return to work without the necessity of a work hardening or conditioning program.