

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 14, 2004

Re: IRO Case # M2-04-1225

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Denial letters 2/3/04, 3/3/04
3. Request for reconsideration 2/18/04
4. Designated doctor evaluation 2/27/04
5. Impairment evaluation 3/3/04
6. MRI right shoulder report 1/7/03
7. Orthopedic care notes
8. Operative report 3/24/03
9. Examination notes
10. Initial evaluation pain clinic 11/3/02
11. Physical therapy notes
12. Pain management notes
13. Work hardening evaluation 11/10/03
14. FCE 11/11/03, 1/21/04

History

The patient suffered a right shoulder injury and developed chronic shoulder pain. It appears that this was complicated by a partial thickness rotator cuff tear, AC joint arthropathy and subacromial impingement. After failing extensive non-operative management, the patient underwent arthroscopic debridement of the partial thickness rotator cuff tear, subacromial decompression and partial distal clavisectomy on 3/24/03. Post operatively the patient received extensive physical therapy. A work hardening program was recommended to address the patient's psychological and social issues to enable her to return to work.

Requested Service(s)

Work hardening program x 20 sessions

Decision

I disagree with the carrier's decision to deny the proposed work hardening program.

Rationale

The medical records reveal that the patient has extensive psychological and social barriers that require a multi-disciplinary approach to get her back to work. The work hardening evaluation was very extensive and describes social issues as well as pain issues that adversely affect the patient's ability to work. A one-time work hardening program is appropriate in an effort to return the patient to work.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

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

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 18th day of May 2004.