

07/12/2004

MDR Tracking #: M2-04-1440-01
IRO #: 5284

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Chiropractor. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

___ was injured on ___. He worked as a carpenter when he suffered an on the job injury. It is noted that the patient was cutting wood with a saw when he lacerated his left hand. He initially presented to ___ with four cuts of varying lengths and depths to the top of his left hand. He was treated and released by ___. He presented to ___ on 8/13/03 and began physical medicine and modalities treatments. He was referred to ___, ___ and ___ for various consultations. A FCE was performed on 9/15/03. A designated doctor, ___ placed the patient at MMI with an 18% impairment.

REQUESTED SERVICE

The requested service is the prospective medical necessity of a 30-visit work hardening program.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer indicates the determination is based upon the Medical Disability Advisor, Industrial Rehabilitation-Techniques for Success and Occupational Medicine Practice Guidelines. Specifically a work hardening program should be considered a goal oriented, highly structured individualized treatment program. The patient should have specifically identifiable deficits or limitations in the work environment and have specific goals that the program can address. Generic limitations such as decreased range of motion and strength are not appropriate. Work hardening is designed with specific job simulation duties in mind as opposed to work conditioning which does not necessarily contain real job simulations.

Since no specific job task is identified which the patient cannot perform, work hardening would not be considered medically necessary. In addition, it appears that the patient is currently pain focused and has moved into a chronic pain pattern. This could compromise the efficacy of a work hardening program. It should be noted that the 'letter of medical necessity' by ___ does identify physical limitations in the FCE including: decreased left hand grip strength, lifting capacity, fine motor skills, moderate pain and

behaviors with weighted activities, low tolerance for functional tasks and low biomechanical tolerance for sustained activity. However, there is little to no objective documentation in the file provided to support these statements. Lastly, the DD report places the patient at MMI with an 18% impairment. MMI is defined as the point when a patient will not gain further material recovery or lasting improvement and that the injury is presumed to be permanent. The reviewer indicates the understanding of the entitlement to future medical benefits but disagrees with the necessity of specifically a work hardening program.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

___ IRO, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 13th day of July 2004