

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-0851.M2

September 10, 2004

Alliance Pain Centers/Jade Malay, D.C.
Attn: Melissa Lynn
1912 Hebron Pkwy #104
Carrollton, Texas 75007

VIA FACSIMILE
Service Lloyds Insurance Co.
C/o Harris & Harris
Attn: Wysteria Hutcherson

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter B**

**RE: MDR Tracking #: M2-04-1714-01
TWCC #: ____
Injured Employee: ____
Requestor: Alliance Pain Centers/Jade Malay, D.C.
Respondent: Service Lloyds Ins. Co. c/o Harris & Harris
MAXIMUS Case #: TW04-0373**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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 MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old female who sustained a work related injury on _____. The patient reported that while at work she injured her left shoulder. A MRI of the left shoulder and cervical spine performed on 3/28/03 revealed moderate supraspinatus tendinopathy with a small full thickness tear of the supraspinatus tendon at it's anterior leading edge, fluid in the subacromial/subdeltoid bursa, 3mm central disc protrusion at C5-6 ridging the cord surface, but not lateralizing, 1mm disc protrusion lateralizes to the left at C6-7, and reversal of the cervical curvature in the mid and lower cervical spine. The diagnoses for this patient have included internal derangement-shoulder, shoulder sprain/strain, and disc displacement without myelopathy. The patient initially was treated with conservative care. On 7/3/03 the patient underwent surgery on the left shoulder and postoperatively was treated with physical therapy/rehabilitation and a work hardening program. The patient is being recommended for further work hardening.

Requested Services

Work Hardening Program.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter 2/17/04
2. Evaluation 4/4/03
3. Chart Notes 5/7/03 – 1/7/04
4. MRI reports 3/28/03
5. SOAP Notes 3/13/03 – 4/8/04

Documents Submitted by Respondent:

1. FCE 5/10/04 and 6/10/04

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 42 year-old female who sustained a work related injury to her left shoulder on _____. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included internal derangement-shoulder, shoulder sprain/strain, and disc displacement without myelopathy. The MAXIMUS chiropractor reviewer further noted that the patient underwent shoulder surgery on 7/3/03 and postoperatively was treated with physical therapy/rehabilitation and a work hardening program. The MAXIMUS chiropractor reviewer indicated that the patient is being recommended for further work hardening. The MAXIMUS chiropractor reviewer explained that the patient requires further work hardening to prepare this patient for release into the work force. The MAXIMUS chiropractor reviewer also explained that the patient has responded well to the work hardening

program, however she requires further treatment to ensure that she does not regress. Therefore, the MAXIMUS chiropractor consultant concluded that the requested additional work hardening program is 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,
MAXIMUS

Elizabeth McDonald
State Appeals Department

cc: Texas Workers Compensation Commission

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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 10th day of September 2004.

Signature of IRO Employee
Name Elizabeth McDonald