

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-1196.M2

09/13/2004

MDR Tracking #: M2-04-1871-01

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 who is board certified in Rehabilitation. The reviewer is on the TWCC ADL. 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 ___ while working for ___. ___ is 5'9" and weighs approximately 230-240 lbs. He apparently has elevated blood pressure, slight tachycardia and a respiration rate according to the records. Also according to the records, the patient was injured when his work vehicle was struck from behind by an eighteen wheeler. He presented to the hospital and soon thereafter to the office of ___. Diagnostic testing was performed in the form of multiple MRI's to the left knee, cervical spine, lumbar spine and brain. Active therapy was performed until a surgical procedure was performed on the left knee. Apparently, dental work was necessary due to the violent impact. A designated doctor examination was performed by ___ on 4/27/04 and the patient was found to not be at MMI. An FCE of 6/22/04 indicates that there is a good prospective outcome for a work hardening program.

Documentation reviewed includes but is not limited to the following from both the requestor and respondent: Request for preauthorization 7/20/04, Initial FCE 6/22/04, Lumbar ROM report 6/22/04, Cervical ROM report 6/22/04, notes from the ___, DD report by ___, case summary dated 8/30/04 by ___, nonauthorization of work hardening report dated 6/29/04 and 7/20/04, 11/3/03 Review Med report, 9/16/03 C-spine and lumbar MRI, Initial Medical Report 10/10/03, Notes from ___, 12/19/03 EMG report, Operative report 1/8/04 and 2/20/04 note from ___.

REQUESTED SERVICE

The requested services include a 30-session work hardening program.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer notes that the FCE indicates that there is definite potential and likelihood for improvement with a tertiary treatment protocol. ___ is deconditioned, suffers from complicating factors and is not performing at his required PDL. It is uncertain if he will be able to return to work at his previous PDL; however, according to the Medical Disability Advisor and Functional Capacity Evaluation by ___ due to the fact that the program will likely result in increased capacity to perform work or increase functional ability it is a medically necessary program. This is further supported by TLC 408.021. The program should be monitored closely to ensure that the patient is improving at two-week intervals. Should improvement not be noted, then the program can be terminated at that time for non-improvement or non-compliance. The program must be of a multi-disciplinary nature and must result in a transition into return to work for this patient (with retraining if necessary).

___ 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. ___ believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of ___, 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 20th day of September 2004.