

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-05-0010-01
IRO Certificate Number: 5259

September 22, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

Sincerely,

CLINICAL HISTORY

Records reviewed included:

1. ____ notes from August 2004 – September 2004;
2. PT and OT notes/reports from 1998;
3. TIRR reports and History and Physicals from 1998 through August 2004; and
4. ____ reports from 2004.

48-year-old obese female status post accident _____. She has had multiple hospitalizations and continues to require frequent lymph edema management treatments, as well as overall assistance.

REQUESTED SERVICE(S)

Twenty-four hour care for activities of daily living function; 7/21/04 – 7/21/05.

DECISION

Uphold previous denial.

RATIONALE/BASIS FOR DECISION

This patient has no need for night time assistance. Once in bed she has no cognitive or mobility dysfunction that necessitates assistance, or that precludes her from accessing help. It is the standard of care for this patient, as described in the records provided, to receive therapies and assistance, daily; but no more than six to eight hours per day, as necessary. Reference medical literature in Dr. Randall Braddom's text *Physical Medicine and Rehabilitation*.

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) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

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 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission

P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with Commission Rule 102.4(h), 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 23rd day of September 2004.