

October 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0056-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:

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

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

Clinical History

This case concerns a 36 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right knee. Initially the patient underwent x-rays of the right knee and was given the diagnoses of knee sprain/strain, knee pain, r/o meniscus tear of the knee, and knee swelling. The patient was initially treated with physical therapy consisting of EMS, ultrasound, massage, and hot/cold pack. On 12/9/03 the patient underwent an MRI of the right knee that revealed a small joint effusion, osseous contusion of the medial femoral condyle, partial thickness tear involving the inferior aspect of the ACL, and no medial or meniscal tear seen. The patient subsequently underwent right knee diagnostic arthroscopy on 3/29/04 for the diagnosis of partial tear of the anterior cruciate ligament. Postoperatively the patient was treated with further physical therapy and has been recommended for 20 sessions of a work conditioning program.

Requested Services

Work Conditioning Program times 20 sessions.

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

Documents Submitted by Requestor:

1. Initial Medical Narrative Report 11/25/03
2. FCE 6/10/04
3. Operative Report 3/29/04
4. MRI report 12/9/03
5. Office Notes 6/21/04 – 9/3/04
6. SOAP Notes 4/13/04 – 6/10/04

Documents Submitted by Respondent:

1. Notice of Utilization Review Findings 8/10/04, 8/25/04.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ----- physician reviewer noted that this case concerns a 36 year-old male who sustained a work related injury to his right knee on -----. The ----- physician reviewer indicated that the patient had been treated with physical therapy followed by arthroscopic surgery followed by postoperative physical therapy. The ----- physician reviewer noted that by 5/14/04 the patient was ambulating without crutches and by 6/4/04 the patient had decreased pain. The ----- physician reviewer indicated that the patient underwent an FCE on 6/10/04 and was found to have 4+/5 strength in his right lower extremity and left lower extremity was noted to have problems. The ----- physician reviewer noted that the patient was found to have severe limitations in stair climbing/standing, squatting and was overall felt to be at light to medium physical demand level for work. The ----- physician reviewer explained that the patient's job requires him to stand 12 hours a day, lift, squat, crawl and climb carrying up to 30-70 pounds. The ----- physician reviewer also explained that a work hardening program specifically targeting activities required for patient's job performance is required and medically necessary for optimal rehabilitation and return to work. The ----- physician reviewer further explained that targeted and a structured work conditioning program has been shown to have a reduced number of sick days in some workers with chronic back pain. Therefore, the ----- physician consultant concluded that the requested work conditioning program times 20 sessions 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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 15th day of October 2004.

Signature of IRO Employee

Name