

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number	
MDR Tracking Number:	M2-05-1069-01
Name of Patient:	
Name of URA/Payer:	Zurich American Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	San Antonio Accident/Injury Care
Name of Physician: (Treating or Requesting)	Richard Alexander, DC

April 1, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

Medical Review of Texas (MRT) 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 MRT.

April 1, 2005  
Notice of Independent Review Determination  
Page 2

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc:

San Antonio Accident/Injury Care  
Richard Alexander, DC  
Texas Workers Compensation Commission

RE:

CLINICAL HISTORY

Available information suggests that this patient reports a work related injury to the right elbow and left wrist on \_\_\_\_\_. The patient underwent surgery to repair a fracture of the right radial head and left distal radius with T.R. Weissflog, MD, on 03/11/03. The patient began post-operative therapy with Health South on 05/29/03. The patient apparently requested a change of treating doctors and began seeing Richard Alexander, DC, on 06/09/03. The patient also began seeing another orthopedic hand specialist, Donna Boehme, MD, on 07/28/03. Designated doctor evaluation was made on 07/29/03 by a Paula Lyons, MD, suggesting that the patient was badly deconditioned and had not reached MMI as of this date. An 11/05/03 MR Arthrogram of the left wrist was ordered by Dr. Boehme and suggests need for second surgical repair. Following a second orthopedic opinion and psych evaluation, a second surgical repair of the left wrist is performed 06/03/04. FCEs performed suggest that current PDL is sedentary and job demands require heavy work capacity. Multiple work hardening and repeat FCE requests are made by treating chiropractor, Dr. Alexander, from 10/27/04 to 01/14/05 but appear to be denied by peer review.

REQUESTED SERVICE(S)

Determine medical necessity for requested Work Hardening Program as recommended x20 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Available records **do appear to support medical necessity** for an appropriate Work Hardening program as recommended by treating doctor and consulting specialty physicians. This is further supported by multiple surgical interventions, designated doctor's findings of deconditioning and initial FCEs placing PDL at sedentary with job demands requiring heavy work capacity.

1. TWCC MFG guidelines for Work Hardening and Work Conditioning Programs; (Medicine GR);
2. CARF, Commission on Accreditation of Rehabilitation Facilities, 1990 Standards Manual.
3. Schonstein E, Kenny DT, Keating J, Koes BW. Work conditioning, work hardening and functional restoration (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

## 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 4<sup>th</sup> day of April 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell