

April 25, 2005

VIA FACSIMILE
Nestor Martinez, DC
Attn: Gracie Diaz

VIA FACSIMILE
Zurich Ins. Co.
C/o FOL
Attn: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1224-01
TWCC #:
Injured Employee:
Requestor: Nestor Martinez, DC
Respondent: Zurich Ins. Co. c/o FOL
MAXIMUS Case #: TW05-0065

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 physician on the MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on _____. The patient reported that while at work he injured his right elbow and knee when he was walking across a guardrail and slipped and fell. An MRI of the right knee performed on 7/1/04 showed evidence of a grade 3 abnormality of the posterior horn of the medial meniscus extending to the inferior articular surface. An MRI of the right elbow performed on the same day showed evidence of an injury to the brachial tendon and its insertion on the coracoid process as well as an expansive lesion of

the proximal radius consistent with a possible osteochondroma 12mm in diameter. On 8/23/04 the patient underwent a medial meniscal tear repair of the right knee. Following surgery the patient was treated with physical therapy and participated in a work hardening program. An additional 20 sessions have been recommended for this patient to bring him to the heavy physical demand work level.

Requested Services

Work Hardening times 20 visits.

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

Documents Submitted by Requestor:

1. Subsequent Medical Reports 6/23/04 – 3/21/05
2. Work Capacity Evaluation 2/8/05
3. Functional Capacity Assessment 12/30/04
4. Work Hardening Assessment Psychological History 12/29/04
5. Operative Note 8/23/04
6. MRI reports 7/8/04

Documents Submitted by Respondent:

1. Pre-Authorization 2/14/05 and 2/25/05

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a male who sustained a work related injury to his right knee on _____. The MAXIMUS physician reviewer indicated that the patient underwent surgical treatment on 8/23/04 followed by postoperative physical therapy. The MAXIMUS physician reviewer noted that the patient progressed with the postoperative therapy but that he was not able to return to work. The MAXIMUS physician reviewer also noted that the patient underwent an FCE on 12/30/04 and was found to be at the light medical physical demand level and subsequently participated in a work hardening program through 2/8/05. The MAXIMUS physician reviewer indicated that at that time, the patient was found to have improved in all functional areas required for his job. The MAXIMUS physician reviewer explained that a structured and job specific rehabilitation is more beneficial in returning a patient to work than a unsupervised exercise program without set goals and objectives. The MAXIMUS physician reviewer also explained that the patient has shown improvement with work hardening and is expected to continue to show improvement. The MAXIMUS physician reviewer further explained that it is medically necessary for the patient to continue work hardening because there is an expectation that this patient will improve. Therefore, the MAXIMUS physician consultant concluded that the requested work hardening times 20 visits 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

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 25th day of April 2005.

Signature of IRO Employee: _____
External Appeals Department