

NOTICE OF INDEPENDENT REVIEW DECISION

September 12, 2002

RE: MDR Tracking #: M2-02-0540-01
IRO Certificate #: 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 55 year old female sustained a work-related injury on ___ when she fell onto her buttock and injured her lower back and tailbone. An MRI of the lumbar spine revealed an annular bulge and annular tear at L5-S1. The patient was treated with physical therapy but still complains of lower back pain radiating down her right leg. The treating chiropractor has recommended that the patient participate in a work hardening program.

Requested Service(s)

Work hardening program at 5 times per week for 6 weeks

Decision

It is determined that the work hardening program at 5 times per week for 6 weeks is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Work hardening programs are indicated for patients who are unable to return to work. Based on the medical record documentation, the patient has been gainfully employed since the injury in ___, even though she states that she has been in some pain since the injury. To remove her from work to go through work hardening when she has been able to work all these years post trauma conflicts with the evidence regarding work related injuries. On the first visit to the treating chiropractor, her pain is rated as a 5 on a 10 scale upon physical examination. Eight months later, on 05/14/02, the office notes report her describing her pain at 5 on a 10 scale, and 7 on a 10 scale on 05/28/02. The medical record documentation did not indicate that the patient received benefit from the rehabilitation exercise program already performed nor did the documentation indicate that conservative care had failed. A work hardening program would be of no benefit since there is no evidence that the patient received any benefit from the physical rehabilitation exercise program.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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,