

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-02-3318.M2**

May 16, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0543-01

IRO Certificate No.: I RO 5055

Dear

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a Chiropractor.

**THE PHYSICIAN REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.**

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 **ten (10)**

days of your receipt of this decision (28 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 **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** 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  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 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.

**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 16<sup>TH</sup> day of May, 2002.**

Sincerely,

Secretary & General Counsel

#### MEDICAL CASE REVIEW

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning Case File #M2-02-0543-01, in the area of Chiropractic Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of work hardening program: \_\_\_\_
2. \_\_\_\_ correspondence and documentation.
3. Evaluations and correspondence: \_\_\_\_ (DOE 02/26/02); DDE report (DOE 12/20/01).
4. Functional Capacity Evaluation from \_\_\_\_ (DOE 12/11/01).
5. Radiology, MR imaging, and Neurology reports.

B. SUMMARY OF EVENTS:

Certification for work hardening services by \_\_\_\_\_, which was denied on 02/06/02, due to the patient's work capacity being at a sedentary level.

Non-certification decision appealed by \_\_\_\_\_ denied on 02/13/02, due to patient's job classification being light, lack of pathology present, and confusion of working diagnosis.

C. OPINION:

1. I AGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE ABOUT THE ISSUE OF MEDICAL NECESSITY OF WORK HARDENING SERVICES FOR THIS PATIENT.
2. The FCE that was performed on 12/11/01 does not give psychosocial data that would suggest a work hardening program over a work conditioning program. Simply stating that the patient has a fear of re-injury or suffers from somatization symptomatology is not enough criteria per existing Texas Spinal Treatment Guidelines and the Worker's Compensation Fee Guidelines (Texas) to enroll a patient into a work hardening program.
3. Screening criteria utilized take reference with extracted rehabilitation protocols of the American Chiropractic Rehabilitation Board, strengthening guidelines set forth by the National Strength and Conditioning Association, referral data, and practice experience.

D. ADDITIONAL COMMENTS:

I feel that the patient will be able to benefit from a highly structured, goal-oriented, work-focused rehabilitation program utilized in work conditioning. Allowing this patient to continue with a home rehabilitation program in which she is making little/no progress is not a beneficial course of action. Under supervision, a greater therapeutic gain will be more readily realized. A program that is 4 weeks in duration at 4-6 hours each day at a daily frequency seems most appropriate. Additional therapeutic applications will require further Functional Testing. MMI will be reached after the course of this RTW focused program.

If the patient has psychosocial testing and a deficit is shown, then this patient's case will be better served in a work hardening environment.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

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Date: 15 May 2002