

NOTICE OF INDEPENDENT REVIEW DECISION

June 25, 2002

Requestor

Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0726-01
IRO Certificate #: 4326

____ 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 28 year old female sustained a work related injury on _____. While lifting a trash can, she felt a sharp pain in her low back that shot down her left leg. After several days, the patient was evaluated by _____ and is currently still being treated by him. The patient's treatment to this point has included therapeutic exercise, modalities and general chiropractic care. A lumbar MRI performed on 02/25/02 revealed a 2mm herniated nucleus pulposus (HNP) at L5/S1. The patient was evaluated in March by _____ an orthopedic specialist and has received epidural steroid injections. The patient continues to complain of intermittent low back pain. The treating chiropractor has recommended that the claimant participate in a work hardening program.

Requested Service(s)

Work hardening program.

Decision

It is determined that a work hardening program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has undergone an extensive course of conservative care under the administration of ____, the attending chiropractor. This course of care has included chiropractic manipulation treatment as well as passive and active care. This course of treatment including months of active care has apparently not yielded any significant positive results as the patient reported similar pain levels throughout the months of conservative care. There is no clinical evidence to suggest significant gains in progress and indications that passive/active care within the requested program will be efficacious as well. Additionally there is no comparative data, (i.e., re-examination, interim FCE's or ROM data), to substantiate the continuing need for therapy as well as the requested upper level program. Finally, there is no indication within the daily notations that the patient's psychological status or somatization is of any concern. Therefore, documentation provided fails to substantiate the medical necessity and appropriateness of the requested work hardening 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.

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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 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.**

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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,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division,
TWCC