

March 17, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0659 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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 care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

This patient was injured on her job as a laborer who moves appliances when moving some washing machines that were stacked. She felt an immediate onset of low back pain and took off of work for 1 week voluntarily as vacation time. She returned to work 1 week later and was unable to work due to low back pain. She eventually sought care from ___, who has treated her with conservative care. Her case has been co-managed by ___, who recommended a work hardening program for this patient. FCE demonstrated a borderline sedentary patient whose job classification is "heavy". MRI reveals a lumbar disc protrusion at L4/5 which impacts the anterior thecal sac.

DISPUTED SERVICES

The carrier has denied the medical necessity of the requested work conditioning program.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The FCE is quite graphic that this patient is indeed unable to perform the job that she does and it does not seem to indicate that there is a serious functional overlay. The patient apparently has little or no psychological component to this injury and the most appropriate method of treating her injury is with a work conditioning program. Clearly, the MRI demonstrates a lumbar pathology that has not been fully treated and the delay in getting appropriate care for such an injury does increase the chance of further complications. I believe the treating doctor is correct in his assertion that work conditioning is appropriate in this case.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 17th day of March 2003