

July 10, 2003

CORRECTED DECISION

Decision submitted on 06/26/03 had the incorrect MDR# and was, consequently, not sent to all interested parties.

Re: MDR #: M2-03-1049-01
IRO Certificate No.: 5055

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 physician who is Board Certified in Chiropractic Medicine.

Clinical History:

This male claimant suffers pain in his lower back, neck, top of the left shoulder, and right knee following a work-related accident on _____. He was evaluated on 09/19/02, and treatment was begun. The patient had additional diagnostic testing that revealed positive findings. He had consults with providers other than the chiropractor.

Disputed Services:

Work hardening and work conditioning.

Decision:

The reviewer partially agrees with the determination of the insurance carrier. The reviewer is of the opinion that the work hardening program is medically necessary; but the work conditioning program is not medically necessary in this case.

Rationale for Decision:

The records provided for review indicate that this patient has received appropriate treatment to date and would definitely benefit from a work hardening program. The FCE clearly indicates the patient is not currently able to function at his return-to-work required status. The work hardening psychosocial pre-screening psychological/clinical interview on 04/29/03 revealed no contra-indications to participation in a work hardening rehabilitation program at this time.

However, the psychological interview did identify psychological factors that may be injury-related and would interfere with rehabilitation, thus limiting progress if not addressed. It appears that the patient will require a multi-disciplinary work hardening program in which he is afforded weekly psychological group counseling and psycho-educational support.

Due to the psychological factors, this patient would not adequately benefit from a work conditioning program. The patient has had primary and secondary levels of care. Therefore, at this time, it is reasonable, usual, customary, and medically necessary for him to progress into a work hardening program.

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 care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to 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 June 10, 2003.

Sincerely,