

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 3, 2003

RE: MDR Tracking #: M2-04-0401-01
IRO Certificate #: 5242

___ 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 Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer 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

According to the supplied documentation, it appears that the claimant injured his low back on ___ when he was lifting a buffer machine at work. The claimant was treated and released on 06/04/2003 at a local emergency room with a diagnosis of a back strain. Plain film x-rays revealed a normal lumbar spine. The claimant presented to ___ on 06/19/2003 for evaluation and treatment. A diagnostic ultrasound was performed on 08/05/2003, which revealed some joint and ligamentous inflammation in the lumbar and sacral regions. The claimant was treated with active and passive chiropractic modalities approximately 38 times. Functional Capacity examinations were performed on the claimant 2 times. The documentation ends here.

Requested Service(s)

Please review and address the medical necessity of the proposed services including work conditioning.

Decision

I agree with the insurance company that a work conditioning is not medically necessary.

Rationale/Basis for Decision

According to the emergency room documentation, the claimant sustained an acute lumbar strain on ___. ___ diagnosed the claimant with a lumbar strain, lumbar disc disorder, and lumbar/sacral neuritis. A functional capacity exam performed on 08/29/2003 revealed that the claimant was at a medium work level. A follow-up functional capacity exam on 10/02/2003 revealed that the claimant was at a light work level.

A NCV/EMG study reported that the claimant had evidence of a bilateral lumbosacral radiculopathy. A daily note from the treating doctor on 09/24/2003 stated that the claimant was still unable to work due to the severity of his condition. Since the first FCE stated that the claimant was at a medium work level, he should have been able to return to work with possible restrictions according to his job demands. The second FCE performed after an additional month of therapy revealed that the claimant was at a light work level. There was no documentation supplied that supports any rationale as to why the claimant would decrease his functional capacity with additional therapy. The only reasonable explanations are that the claimant is magnifying symptoms, or that continued therapy is causing the claimant to become weaker. In either case, returning to work is the only supported decision that can be made. The objective documentation did not support any additional therapy or support the need for a work conditioning/hardening program.

YOUR RIGHT TO REQUEST A HEARING

Either party to 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** (ten) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.