

February 11, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter**

MDR Tracking #: M2-04-0617-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 35 year-old male who sustained a work related injury on ___. The patient reported that while at work he was climbing up a ladder carrying a tarp when he injured his low back. On 8/14/02 the patient underwent an NCV/SSEP/DSEP that showed bilateral sensory disturbance at the L% and S1 levels. A MRI dated 10/18/02 showed annular bulge with a central disc protrusion at L4-L5, bilateral degenerative facet changes, annular tear, disc bulge with protrusion at L5-Si, and mild osteophytic spurring at the L1-L2 level. The diagnoses for this patient have included lumbar disc displacement, muscle spasm, disturbance of skin sensation, and radiculopathy. Treatment for this patient's condition has included joint mobilization, myofascial therapy, rehabilitation exercises, Russian electric muscle stimulation, and neuromuscular reeducation.

Requested Services

Work Hardening Program times 8 weeks.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 35 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar disc displacement, muscle spasm, disturbance of skin sensation, and radiculopathy. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included joint mobilization, myofascial therapy, rehabilitation exercises, Russian electric muscle stimulation, and neuromuscular reeducation.

The ___chiropractor reviewer explained that the patient's diagnoses history and individual response to treatment rendered, the requested work hardening program is medically necessary. Therefore, the ___ chiropractor consultant concluded that the requested work hardening program times 8 weeks is medically necessary to treat this patient's condition at this time.

This decision 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.

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 a hearing should be sent to:

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

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. (Commission Rule 133.308(t)(2))

Sincerely,

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 11th day of January 2004.