

March 2, 2004

MDR Tracking #: M2-04-0855-01

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 proposed care 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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). 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

___ was injured at work when he fell, hitting his back on a piece of machinery. He was diagnosed with a lumbar strain. His treating doctor has recommended work conditioning/work hardening programs for return to work. Insurance carrier has denied claim as not reasonable or necessary.

REQUESTED SERVICE

A work conditioning program, 5x per week for 6 weeks, is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient presented with complaint of low back pain. His complaint began in ____. The carrier feels that a "contusion" does not warrant work conditioning and that the patient should be prescribed home exercise. The actual diagnosis was lumbar strain. The documentation shows that the doctor has recommended a work-conditioning program and believes it is necessary. FCE clearly shows that the patient is not functioning within the physical demand category required by his job. Clearly, it would be nice to be able to send a patient home to rehabilitate, but there would be no supervision and chances are good that the tasks would not be carried out, or would be done improperly, and the patient would be at risk for further injury. There is, of course, no guarantee that this patient will not go back to work and hurt himself again, no matter what is done, however, work conditioning affords him a better chance at return to his job and carry out his duties without significant risk of re-injury. I recommend that work conditioning be approved for this patient.

Given the diagnosis of a strain, this should significantly ready him for return to work in his physical demand category without further need for work hardening.

___ 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 by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

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 2nd day of March 2004.