

April 5, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0955-01

___ 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 physician 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. This physician is board certified in occupational medicine, preventative medicine, and public health. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 36 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his back when he attempted to lift a 200-pound dummy. On 7/30/03 the patient underwent a lumbar laminectomy at the L4-L5 and L5-S1 levels, bilaterally with discectomy and foraminotomy. Following surgery, the patient was treated with active and passive rehabilitation therapies. On 11/30/03, the patient was referred for a work conditioning/hardening program and completed four weeks of this on 1/22/04. The patient has been referred for further work hardening.

Requested Services

Work Hardening Program 5 times weekly for 4 weeks.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 36 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that on 7/30/03 the patient underwent a lumbar laminectomy. The ___ physician reviewer also noted that the patient had 6 plus weeks of conditioning and a prior 5 plus weeks of physical therapy. The ___ physician reviewer further noted that continued work conditioning has been requested. The ___ physician reviewer indicated that there is no evidence in the documentation provided that would

indicate that continued conditioning or work hardening would result in this patient's return to work as a firefighter. The ___ physician reviewer explained that this job description is amongst the heaviest type of work there is. The ___ physician reviewer also explained that the longer this patient stays out of work, the less likely it would be that he would return to full duty. The ___ physician reviewer indicated that the patient has had pain since ___ and that it would be unlikely that this patient would be totally pain free. The ___ physician reviewer explained that because of the nature of this patient's back pain, duration of pain, the patient's weight, diagnosis of degenerative changes and type of work he performs, his prognosis for returning to his usual occupation is fair. The ___ physician reviewer also explained that the patient had 6 plus weeks of condition and a prior 5 plus weeks of physical therapy.

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 5th day of April 2004.