September 20, 2004

MDR Tracking #: M2-04-1315-01
IRO #: 5284

___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.

This case was reviewed by a licensed Doctor of Chiropractic who is board certified in rehabilitation. 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

The patient is a 20-year of age female who was injured on ___ when she was kicked in the buttocks by a fellow employee. She has received chiropractic treatment from ___, DC. The notes indicate a minor disc injury at L5; neurodiagnostic imaging revealed bilateral L6 (per notes) radiculopathy and S1 left radiculopathy. FCE dated 3/9/04 indicates the patient does not meet the required standards as stated by the FCE. According to the FCE documentation the patient's positional tolerance met the requirements for 6 of 9 required activities. Psychological evaluations were performed on 12/16/03 and 3/16/04 by Susan Wade, LMSW-BCIA. In the latest evaluation, ___ indicates "her anxiety provoking circumstances…did not ameliorate, in fact, they increased…___ reports ruminating thoughts and flashbacks…increased startle reflex…she is afraid to answer her phone for fear of her perpetrator calling." ___diagnosed an acute stress disorder and recommends individual cognitive therapy in conjunction with a work hardening program. This program was denied times two by ___ based upon ACOE Guidelines (unstated chapter or table of Guidelines) and ___, DC based upon ACOE Guidelines (unstated chapter or table).

REQUESTED SERVICE

Work hardening program times 10 sessions.

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer indicates that this decision is based upon the American College of Occupational and Environmental Medicine, Occupational Medicine Practice Guidelines, Second Edition and The North American Spine Society Phase III Guidelines. Specifically, this patient has demonstrated psychological indications of chronicity and lack of substantiative improvement via prolonged absence from work, she is a victim of abuse (at work by fellow coworker) and her GAF score is a 65. She has employment related disability factors including an adversarial job relationship. She has co-existing medical and psychological conditions, which hinder advancement in treatment. A work hardening program with its inherent psychological counseling should help the patient return to a functional physical and psychological status in a short period of time. This is based upon Table 5-1, Table 12-8, pg. 87 and other portions of the Occ. Med Guidelines.

___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 ___, Inc, dba ___, 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 this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

Sincerely,

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 26th day of May 2004.