



Specialty Independent Review Organization, Inc.

December 22, 2004

Hilda Baker
TWCC Medical Dispute Resolution
7551 Metro Center Suite 100
Austin, TX 78744

Patient:
TWCC #:
MDR Tracking #: M2-05-0339-01
IRO #: 5284

Specialty IRO 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 Specialty IRO for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Specialty 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 Chiropractor. The reviewer is on the TWCC ADL. The Specialty IRO 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 Specialty IRO 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

According to the records received, the injured worker ___ was injured on ___. The patient was working for Wal-Mart as a stocker when he was injured. The patient was stocking cases and lifting heavy boxes when he injured his low back with pain radiating to the left leg. The patient was lifting and moving heavy cases of merchandise. The injured worker then sought the care of Dr. V. Dr. V then initiated a course of conservative care. According to the records, the injured worker is unable to work due to his injuries.

Numerous treatment notes, diagnostic tests, staffing notes, evaluations, and other documentation were reviewed for this file. Records were received from the insurance carrier and from the treating providers.

Records included but were not limited to: Medial Dispute Resolution paperwork, UniMed Direct Review Determinations, Pre-Authorization Reconsideration from Dr. V, IRO Pre-authorization dispute by Dr. V, Work Hardening Pre-authorization requests by Dr. V, RME by Dr. H, ___ Job Description, Evaluations by Dr. O, TWCC 69 and IME by Dr. R, Report by ___, Records form Dr. V, Electrodiagnostics from Dr. R, MRI by Up & Open Imaging, Arkansas Claims Management Report, Clear Sky MRI, Electrophysiological Study by Dr. S and an MRI by Texas Imaging & Diagnostic Center.

REQUESTED SERVICE

Requested services include a proposed work hardening program.

DECISION

The reviewer disagrees with the previous adverse decision.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, 1996 Medical Fee Guidelines specific to Work Hardening, Industrial Rehabilitation-Techniques for Success, and Occupational Medicine Practice Guidelines. Specifically, a Work Hardening program should be considered as a goal oriented, highly structured, individualized treatment program. The program should be for persons who are capable of attaining specific employment upon completion of the program and not have any other medical, psychological, or other condition that would prevent the participant from successfully participating in the program. The patient should also have specifically identifiable deficits or limitations in the work environment and have specific job related tasks and goals that the Work Hardening program could address. Generic limitations of strength range of motion, etc. are not appropriate for Work Hardening.

The patient had specifically identifiable functional limitations due to his injury. The patient also has psychosocial factors noted in his documentation, which would necessitate work hardening. The patient is identified as a laborer and as a laborer relies solely on his functional abilities to maintain gainful employment. Without proper retraining, ___ could become permanently disabled and unable to return to the workforce as a contributing member of a society. Because ___ is a laborer a heavy emphasis should be placed on restoring ___'s abilities to function in the workplace as a laborer.

Specialty IRO has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Specialty IRO has made no determinations regarding benefits available under the injured employee's policy. Specialty IRO believes it has made a reasonable attempt to obtain all medical records for this review and afforded the requestor, respondent and treating doctor an opportunity to provide additional information in a convenient and timely manner.

As an officer of Specialty IRO, Inc, dba Specialty IRO, I certify that there is no known conflict between the reviewer, Specialty IRO and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,

____, CEO

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 17787, Austin, TX 78744. The fax number is 512-804-4011. 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(u)(2).

Sincerely,

____, CEO

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 _____ 23rd _____ day of _December_____, 2004

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: