



Specialty Independent Review Organization, Inc.

December 17, 2004

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

Patient:
TWCC #:
MDR Tracking #: M2-05-0451-01
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 who is board certified in Rehabilitation. 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

___ was injured on ___ while working for Regulus Integrated Solutions due to an apparent repetitive motion injury. The patient treated with Trenton W, DC with active and passive therapies following a surgical procedure by Dr. L, DO. An FCE was performed on 10/19/04 indicating a sedentary light PDL. However, the notes indicate she had been released from employment prior to this point in time.

Records were reviewed from both the treating doctor and the respondent. Records were requested from the requestor; however, no records were received from the requestor. Records from the respondent include the following: 11/23/04 denial of work hardening program (indicates a 10 visit WC program was approved by Dr. W and the peer reviewer), 11/29/04 list of providers, 11/5/04 peer review appeal by Dr. S, DC, 10/27/04 preauthorization request by

Dr. G, DC, TWCC 60, 10/19/04 FCE by Town East Rehab, 10/13/04 daily note by Dr. W and a WH script by Dr. W. Records from the requestor include some of the above plus the following: 8/17/04 and 9/14/04 reports by Dr. L, DO, 10/14/04 PT review by ____, PT (approves a WC program), 10/14/04 note by Dr. W and 11/2/04 letter of medical necessity for work conditioning by Dr. W.

REQUESTED SERVICE

The requested service is a work hardening program (daily times four W).

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The reviewer agrees with Dr. W that this patient would likely benefit from a return to work program. The patient's need for a return to work program has been demonstrated by the documentation enclosed; however, the most important portion of this program, a job to return to upon which to base the program's goals, has not been demonstrated by the documentation. Due to the lack of goals, the program is found to be not medically necessary as per the presented documentation.

References: Medicare Treatment Guidelines, EBM Guidelines and Council of Chiropractic Physiological Therapeutics and Rehabilitation Guidelines.

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

cc: Specialty IRO Medical Director

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,

Wendy Perelli, 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 21st day of December, 2004

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: