



Specialty Independent Review Organization, Inc.

May 27, 2005

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

Patient:
TWCC #:
MDR Tracking #: M2-05-1334-01
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 reviewed, Mr. ___ was working for Automation Temporary Service as a warehouseman when he was injured in a work related accident on ___. It should also be noted that his claim was initially disputed and the dispute was not resolved until 1-5-2005. ___ was lifting a box of approximately 100 lbs when he felt pain throughout his low back. The patient later had pain radiating down the right hip and right lower extremity. Ms. ___ was initially seen by the company doctor and then later seen by K-Clinic. The patient later changed care to the Texas Work Comp Clinic and was under the care of Dr. Bowen. At some point, the patient switched care to Dr. Miller.

Records were received from the insurance carrier and from the treating provider.

Records included but were not limited to:

- Medial Dispute Resolution paperwork
- Records from Concentra
- Position Statement from Dr. Miller
- FCE from Konrad Kuenstler PT
- Records from Texas Work Comp Clinic
- Report from Metroplex Specialties
- Report from Dr. McPhaul
- Report from Preferred Imaging
- Response from Flahive, Ogden & Latson
- Records from K-Clinic
- Report from Dr. Kechejian
- Records from Dr. Keene
- Designated Doctor report by Dr. Small

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of a work hardening program times 30 sessions.

DECISION

The reviewer agrees with the previous adverse determination.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, 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.

Although the patient had specific identifiable limitation due to his injury as noted in the patient's FCE, it is also noted that ___ does not have a specific job to return to and does not have specific employment goals. At some point during ___' treatment, he worked in a sedentary job. It is also important to note that the accepted compensable areas for ___ only extend to a lumbar

sprain/strain and do not extend to a lumbar disc injury. ___ exceeds the normative treatment data established by the Medical Disability Advisor. This is not to say that ___ does not need additional care or that he does not have a significant injury to his lumbar region, only that the Work Hardening cannot be supported for a lumbar sprain/strain without a specific identifiable goal of employment. It should also be noted that the patient has already been placed at MMI by a Designated Doctor.

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,

Wendy Perelli, 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,

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 27th day of May 2005

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli