July 29, 2005

Re:	**MDR #:**	M2-05-1884-01	**Injured Employee:**
	TWCC#:		**DOI:**
	IRO Cert. #:	5055	**SS#:**

TRANSMITTED VIA FAX TO:
Texas Workers' Compensation Commission
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:
San Antonio Spine & Rehab
Attention: Lori Ruiz
(210) 921-0398

RESPONDENT:
Texas Mutual Ins. Co
Attention: Ron Nesbitt
(512) 404-3980

Dear Mr. ___:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.
Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in Physical Medicine & Rehabilitation and in Pain Medicine and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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:

Texas Workers' Compensation Commission
Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 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.

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 July 29, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/th

REVIEWER'S REPORT
M2-05-1884-01

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
From Requestor:
- Correspondence
- Office notes 01/12/05 – 05/04/05
- Physical performance evaluation 05/04/05
- Electrodiagnostic evaluation 02/10/05
- Operative report 01/28/04
- Radiology reports 07/26/04 – 01/28/05

From Respondent:
- Correspondence

From Neurosurgeon:
- Office notes 03/11/05 – 04/27/05

From Spine Surgeon:
- Office note 01/03/05

Clinical History:
This male claimant suffered a work-related injury on ___. This resulted in severe back pain with radiation down the left lower extremity. He underwent conservative management for his injury, including medication therapy, and active and passive physical therapy, with minimal improvement.

Disputed Services:
Work hardening program X 30 sessions.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that 30 sessions of a work hardening program is medically necessary in this case.

Rationale:
The injured worker would likely benefit from formal instruction in proper body biomechanics, behavioral modifications, and a graduated physical program aimed at regaining his work capacities, such as the work-hardening program would offer. He is not tremendously far from these capabilities based on his physical performance evaluation, thus it is realistic to assume that he has a reasonable chance of achieving these through the recommended program. With regard to the carrier's statement, the reviewer sees no evidence of indications for any further interventional procedures.