July 12, 2005

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

Patient:
TWCC #:
MDR Tracking #: M2-05-1896-01
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 and reviewed, ___ was injured in a work related accident on ___ while working for . ___ was working as a drill rig floor hand when he was making a seal on a well using a checker pipe and he injured his low back. The patient felt an immediate pain in his low back and later felt a tingling extend into his right leg. The patient was initially taken to Texas Med Clinic for treatment. Later the patient sought care of Dr. Flood at San Antonio Spine and Rehab.

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

Records included but were not limited to:
Medial Dispute Resolution paperwork
Texas Mutual utilization reviews
San Antonio Spine & Rehab request for reconsideration
San Antonio Spine & Rehab letter of clarification
Records and treatment notes from San Antonio Spine & Rehab
Case Summary by Texas Mutual
Reports from Dr. Ganc and Rosalind Garza-Harris
Reports from Dr. Zavala
Radiology reports by Dr. Brannan
Reports from Dr. Martinez

REQUESTED SERVICE

The item in dispute is the prospective medical necessity of 30 sessions of work hardening (97545 and 97546).

DECISION

The reviewer disagrees with the previous adverse determination.

BASIS FOR THE DECISION

The basis for the determination is based upon the Medical Disability Advisor, 1996 Medical Fee Guidelines specific to Work Conditioning, 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.

The patient had specifically identifiable functional limitations due to his injury. This is identified in the patient's FCE. ___ has specific limitations in the FCE that could be addressed and improved with a Work Hardening program. ___ also had specific psychosocial factors that are identified that would not the multidiscipline aspect of work hardening to address these factors.

The patient is identified as a physical laborer and without proper retraining ___ could become permanently disabled / restricted from full duty and be unable to return to the workforce without limitations 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,

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 13th day of July 2005.

Signature of Specialty IRO Representative:

Name of Specialty IRO Representative: Wendy Perelli