MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71 **Austin, Texas 78735**
Phone: 512-288-3300 **FAX: 512-288-3356**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1777-01
Name of Patient:	
Name of URA/Payer:	City of San Antonio
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. Brad Burdin, DC

September 12, 2006

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: ___
Dr. Brad Burdin, DC
Division of Workers' Compensation

RE: ___

DOCUMENTS REVIEWED
Available documentation received and included for review consists of records from Drs. Burdin, Lampert, Hirsch, Wilson, MRI reports from Drs Handley and Hess, Mental health evaluation (Churchill) and FCE (Clayton).

CLINICAL HISTORY
Ms. ___, a 23-year-old female, sustained an on the job injury when her foot slipped off a curb while using a weedeater, injuring her right knee, hip and lower back. She had numerous rounds of physical therapy, the knee MRI was positive for bone bruise, degenerative changes of the anterior and posterior meniscus horms and joint effusion. Lumbar MRI was remarkable for multilevel degenerative disc disease, especially at L4/L5, mild bilateral neural foraminal stenosis at L4-5 and a small eccentric focal disc protrusion on the right at L4-L5. Electrodiagnostic testing was unremarkable. She had some steroid injections, one to the sacroiliac joint and one ESI, with moderate success. She is scheduled for a work hardening program

REQUESTED SERVICE(S)
L0456 S3 Posture Brace

DECISION
Denied

RATIONALE/BASIS FOR DECISION
The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustains a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

RE: ___

There is insufficient evidence or clinical rationale provided in the submitted documentation as to why a TSLO of such caliber is required. One of the general concepts of "medical necessity" is that care should be provided in the least intensive, most cost-effective manner. This type of brace does not seem to fit those criteria. These types of brace are usually provided to patients with some degree of spinal instability or requiring some form of post surgical immobilization, neither of which is applicable in this case. There is a now general consensus that back belts are not effective for prevention in LBP, which is essentially the rationale, offered by the treating doctor.

This patient is scheduled for a work hardening program. It is also inappropriate to recommend such an expensive brace prior to completion of a program that may indeed alleviate any necessity for a brace altogether.

References:

European Guidelines for Prevention in Low Back Pain: November 2004

Hansen DT: Topics in Clinical Chiropractic, 1994

Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997;

Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140

Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Giathersburg, MD, 1993;

The Work Loss Data Institute's *Official Disability Guidelines, third edition 2005*

The American College of Occupational and Environmental Medicines *Occupational Medicine Practice Guidelines*,

RE: ___

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), 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 this 12th day of September, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell