

NOTICE OF INDEPENDENT REVIEW DECISION

April 1, 2002

Requestor

Respondent

RE: Injured Worker:  
MDR Tracking #: M2-02-0472-01  
IRO Certificate #:

\_\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic. \_\_\_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

The \_\_\_\_\_ health care professional has determined that the proposed care is medically necessary for treatment of the patient's condition. Therefore, \_\_\_\_\_ disagrees with the previous adverse determination. The specific reasons including the clinical basis for this determination are as follows:

This 52-year-old male sustained injury to his lower back, hip, and knee in \_\_\_\_ 2001. The patient's chiropractor has prescribed a work hardening program for 4 hours a day for 6 to 8 weeks to treat this patient's condition. The patient is now working with restrictions. A MRI performed on 01/02/02 reveals mechanical weaknesses (facet hypertrophy, anterolisthesis, and spondylosis) of the lower lumbar spine. A strengthening program would reduce the likelihood of exacerbation. The functional capacity evaluation performed 01/11/02 reveals limitation of range of motion of the lumbar spine, positional intolerance, deconditioning which indicates that a strength program would be beneficial. Therefore, it is determined that the work hardening program is medically necessary to treat this patient's condition.

This decision by the IRO is deemed to be a TWCC decision and order.

**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. A request for 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 hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, Texas 78704-0012.

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

Sincerely,

Director of Medical Assessment

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 \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: