

NOTICE OF INDEPENDENT REVIEW DECISION

July 26, 2002

RE: MDR Tracking #: M2-02-0495-01
IRO Certificate #: 4326

___ 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 ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer 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.

Clinical History

This 57 year old male sustained a work-related back injury on ___ when he was picking up a "bell-mover" to place on a conveyer belt and it was dropped, lifting and dangling him, from some height, off of the ground. He strained his low back and developed radiating symptoms into the right buttock and lower extremity. The plan of care has included physical therapy, anti-inflammatory medications, Ultram and ESI's. The patient's diagnoses are lumbar degenerative disc disease and right lumbar radiculopathy. The treating physician has recommended a work hardening program for eight weeks.

Requested Service(s)

Work hardening for 8 weeks

Decision

It has been determined that work hardening for 8 weeks is medically necessary.

Rationale/Basis for Decision

The results of the functional capacity evaluation are valid and suggest that the patient may benefit from a work hardening program to help him return to his original job position with ___. The ___ commends work hardening program for 8 weeks with interim evaluation at four weeks to evaluate the patient's progress. Obviously, if at the four-week evaluation progress was such that return to work was not seen to be forthcoming, the program should be discontinued. Therefore, a work hardening program for 8 weeks is medically necessary.

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.

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 **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

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 **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 should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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 (Commission Rule 133.308 (t)(2)).

Sincerely,