

NOTICE OF INDEPENDENT REVIEW DECISION

June 25, 2002

Requestor

Respondent

RE: Injured Worker:

MDR Tracking #: M2-02-0771-01

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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ 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.

Clinical History

This 47 year old female sustained a work related injury on ___ when she slipped on a wet floor onto her left knee, jamming her right knee which hit a metal warmer container. She landed on the left side of her buttock and upper back. In addition, the patient hit her head on the floor. The patient complained of right knee pain, diffuse in the back from the upper parascapular area on the right to low back in the midline along the sacral junction, and headaches. An MRI of the right knee and lumbar spine was performed on 09/06/01. On 10/17/01 the patient underwent arthroscopic surgery of the right knee. The patient continues to complain of pain in the low back and right knee. The treating chiropractor is recommending that the patient undergo a work hardening program for 4 weeks at 5 times per week.

Requested Service(s)

Work hardening program for 4 weeks at 5 times per week.

Decision

It is determined that the work hardening program for 4 weeks at 5 times per week is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

A review of the functional capacity examination indicates strength and range of motion deficiencies in the right knee as well as decreased lumbar range of motion. She has already undergone 2 months of post-surgical rehabilitation and still has deficits noted on the 03/04/02 functional capacity examination. The patient appears likely to benefit from the program and she has a current level of functioning that can interfere with her ability to perform her work tasks. Therefore, the work hardening program is medically indicated.

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.

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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** (ten) 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.**

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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,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division,
TWCC