

December 8, 2004

Re: **MDR #:** M2-05-0311-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission

Attention: Rosalinda Lopez
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:

Valley Spine Medical Center
Attention: ____
(956) 631-2256

RESPONDENT:

TML Intergovernmental Risk Pook
Attention: ____
(512) 867-1733

Dear ____:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:

- Correspondence
- Office notes 08/12/04 – 09/28/04
- Physical therapy notes 09/03/04 – 09/12/04
- Operative report 06/17/04
- Radiology report 04/26/04

Clinical History:

Left knee injury on the job resulting in a small tear of the medial meniscus and partial tear of the anterior cruciate ligament with bone contusion.

Disputed Services:

Ten sessions (2 additional weeks) of a work conditioning program.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the additional weeks of work conditioning is medically necessary in this case.

Rationale:

The physicians, having worked with the patient for some time, have stated that the patient should continue work hardening and rehabilitation of the left knee. Based upon his surgery, his injury, and the usual time needed for repair and rehabilitation of this type of injury, in the reviewer's experience, the patient needs more time. From the documentation provided, he has improved significantly. Two more weeks, that is about 10 more sessions, should be adequate. However, the possibility that the time will need to be further extended exists. This will be able to be determined at the end of the additional 2 weeks.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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 Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 December 8, 2004.

Sincerely,

Secretary & General Counsel