

NOTICE OF INDEPENDENT REVIEW DECISION

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August 3, 2005

Requestor

Lind D. Vo, DC
505 N. Sam Houston Parkway, Suite 170
Houston, TX

Respondent

American Casualty
c/o Burns, Anderson, Jury & Brenner
ATTN: Debrah Derrickson
Fax#: 512-338-5363

RE: Injured Worker: _____
MDR Tracking #: M2-05-1873-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 TMF for independent review in accordance with DWC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF 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 TMF physician reviewer who is board certified in Physical Medicine and Rehabilitation, by the American Board of Physical Medicine and Rehabilitation, licensed by the Texas State Board of Medical Examiners (TSBME) in 1984, and who provides health care to injured workers. This is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, 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. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient was injured on ____.

Requested Service(s)

It is determined that there is no medical necessity for the work hardening program x 30 visits

Rationale/Basis for Decision

Medical record documentation indicates this patient sustained an injury on ____ and was treated with an arthroscopic repair on 01/21/05. He then completed a 3-month postoperative physical therapy program followed by a functional capacity evaluation that reportedly showed him capable of lifting 20 pounds from floor to shoulder. A 6-week work hardening program was requested. Medical record documentation does not indicate the patient's progress with physical therapy or any rationale for the work hardening program. Therefore, the work hardening program x 30 visits is not medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a DWC 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** (ten) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

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

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm
Attachment

cc: _____, Injurer Worker
Program Administrator, Medical Review Division, DWC

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| <p>In accordance with Division 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 3rd day of August 2005.</p> <p>Signature of IRO Employee:</p> <p>Printed Name of IRO Employee:</p> |
| |

Information Used by TMF in Decision

Patient Name: _____

TWCC ID #: M2-05-1873-01

No medical record documentation provided. Based decision on information available in appeal correspondence only.