

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1967-01
Name of Patient:	
Name of URA/Payer:	New Hampshire Ins Co.
Name of Provider: (ER, Hospital, or Other Facility)	Advantage Healthcare Systems
Name of Physician: (Treating or Requesting)	Shawn Henry, DO

September 26, 2006

An independent review of the above-referenced case has been completed by a physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc:
 Advantage Healthcare Systems
 Shawn Henry, DO
 Division of Workers' Compensation

DOCUMENTS REVIEWED

1. SRS Correspondence
2. Advantage Healthcare Medical Records

CLINICAL HISTORY

This is a 34 year old CSA for _____ reported low back injury on ____, while performing the duties of her job. She has completed 12 weeks of a PT program, and an FCE that reveals she is not at the PDL her job requires, which is heavy. She continues to report dull lower back pain, and is limited from returning to work.

REQUESTED SERVICE(S)

Work conditioning program- 10 sessions

DECISION

Approve

RATIONALE/BASIS FOR DECISION

The FCE and patient complaints documented in the record indicate that this is the ideal patient for Work Conditioning program so she can return to work; this is based on the standards of care in the community. Weakness/deconditioning after an injury is the prime indication for work conditioning/work hardening programs. Work conditioning is less demanding than a work hardening program and the sole purpose is reconditioning for RTW. The claimant in this case has documented weakness and deconditioning as a direct result of a work injury, and is not able to return to unrestricted work in her

RE: ____

present status. This type of program is considered an effective means to help her to return to unrestricted/minimally restricted work.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and 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.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

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RE: _____

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

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

In accordance with 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 27th day of September, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell