



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

August 19, 2004

Requestor

Jose Magbag, DC
Attn: Sandra Velazquez
10832 North Freeway
Houston, TX 77037

Respondent

St. Paul Fire & Marine Insurance
c/o Flahive, Ogden & Latson
Attn: Annette Moffett
505 West 12th
Austin, TX 78701

RE: Injured Worker:
MDR Tracking #: M2-04-1601-01
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 TWCC 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's 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 TMF 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 patient injured his lower back on 06/___/02 while lifting wires, resulting in back pain and numbness in the right leg. He has been treated with extensive physical therapy.

Requested Service(s)

Work hardening program for six weeks, eight hours per day, five days per week

Decision

It is determined that the work hardening program for six weeks, eight hours per day, five days per week is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Although the Functional Capacity Evaluation (FCE) documented that the claimant was functioning at a light physical demand level, it did not include documentation of the medical necessity of a multidisciplinary work hardening program. Documentation was not furnished that would support the medical necessity of a multidisciplinary program.

While no medical records were furnished for the time period after the 03/04/04 surgery until the 06/10/04 FCE, the report from the designated doctor recommended physical therapy be continued; however, he did not recommend work hardening. Also, since no treatment records were supplied for that time period, it is unknown for certain if post-operative physical therapy was performed, what it entailed, the patient's response to that care, and how the proposed work hardening program would be different from the previously performed modalities. Therefore, the work hardening program for six weeks, eight hours per day, five days per week is not medically necessary to treat this patient's condition.

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** (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:vn

Attachment

cc: Program Administrator, Medical Review Division, TWCC

In accordance with Commission 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 19th day of August, 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: