



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

October 26, 2004

Requestor

Respondent

American Home Assurance Company
c/o Flahive, Ogden & Latson
Attn: Annette Moffett
Fax #: 512-867-1733

RE: Injured Worker: _____
MDR Tracking #: M2-05-0064-01
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 TMF physician reviewer who is board certified in orthopedic surgery, by the American Board of Orthopaedic Surgery, licensed by the Texas State Board of Medical Examiners (TSBME) in 1983, 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 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 43 year-old male patient injured his neck on ____ when he was involved in a low-speed traffic accident and was ejected from a cart, hitting his head and shoulder on the ground. He continues to complain of headache and constant pain to his neck and shoulder. He has been treated with medication, physical therapy, and acupuncture without relief.

Requested Service(s)

Supraspinous/intraspinous ligament injection under fluoroscopy and 4 to 6 trigger point injections

Decision

It is determined that there is no medical necessity for the supraspinous/ intraspinal ligament injection under fluoroscopy and 4 to 6 trigger point injections to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate an intraspinal ligament injury. Additionally, the magnetic resonance imaging indicates mild degenerative changes and no posterior element injury. Therefore, the supraspinous/intraspinal ligament injection under fluoroscopy and 4 to 6 trigger point injections are not medically necessary to treat this patient's medical 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 26th day of October 2004.

Signature of IRO Employee:

Printed Name of IRO Employee: