



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

February 8, 2005

Requestor

West Houston Chiropractic
ATTN: Liza
10000 Old Katy Rd., #110-B
Houston, TX 77055

Respondent

Travelers Indemnity Company
ATTN: Jeanne Schafer
Fax#: 347-7870

RE: Injured Worker:
MDR Tracking #: M2-05-0618-01
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 Medicine. 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 32 year-old female injured her low back, wrist, ankles, and neck on ___ when she slipped and fell approximately 5 or 6 steps in the parking garage where she worked. She has been treated with surgery, medications and therapy.

Requested Service(s)

Proposed posterior fusion L5-S1, pedicle screws and rods and bone graft with 3 days length of stay

Decision

It is determined that there is medical necessity for the proposed posterior fusion L5-S1, pedicle screws and rods and bone graft with 3 days length of stay.

Rationale/Basis for Decision

Medical record documentation indicates this patient has received an aggressive treatment program and surgical intervention; however, she continues to have on going problems. Significant subjective and objective findings are present that clinically justify the proposed surgery. Appropriate diagnostic testing also confirms a L5-S1 pseudoarthrosis and spinal instability is present.

Due to this patient's continuously documented problems, her ongoing debilitating pain levels, inability to return to gainful employment in a similar position, her previously failed treatments, and the length of time since her original injury date; the proposed posterior fusion L5-S1, pedicle screws and rods and bone graft with 3 days length of stay is 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: _____, Injured Worker
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 8th day of February 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0618-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests

Information Submitted by Respondent:

- Progress Notes
- Consult
- Diagnostic Tests
- Functional capacity evaluation