

NOTICE OF INDEPENDENT REVIEW DECISION

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April 21, 2005

Requestor

Jacob Rosenstein, MD  
ATTN: Cheryl  
800 W. Arbrook, Ste 150  
Arlington, TX 76015

Respondent

Lumbermens Mutual Casualty Co.  
c/o Harris & Harris  
ATTN: Wisteria Hutchenson  
Fax#: (512) 346-2539

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-05-1095-01  
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 Physical Medicine & Rehab, by the American Board of Physical Medicine and Rehabilitation, Inc. licensed by the Texas State Board of Medical Examiners (TSBME) in 1981, 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 48 year-old male injured his back and shoulder on \_\_\_ while trying to assist a patient with standing. The patient fell onto Mr. \_\_\_ injuring him. He has been treated with therapy, medications, surgery and epidural steroid injections.

Requested Service(s)

Lumbar instrumentation block

Decision

It is determined that there is medical necessity for the lumbar instrumentation block to treat this patient's medical condition.

Rationale/Basis for Decision

A lumbar instrumentation block is utilized to determine whether a patient with spinal hardware and lumbar pain is due to the hardware or for another reason. If the block gives relief, then consideration may be given to hardware removal surgery. If the block does not provide relief, the hardware may not be the cause of the pain and other interventions should be considered. In this case, the patient has progressive lumbar pain and spinal hardware. Therefore, the lumbar instrumentation block is 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) 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: \_\_\_\_\_, Injured Worker  
Program Administrator, Medical Review Division, TWCC

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 21<sup>st</sup> day of April 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name: \_\_\_\_

TWCC ID #: M2-05-1095-01

**Information Submitted by Requestor:**

- Progress Notes
- Procedures
- Daily Treatment Notes
- Psychological Review
- Peer Review
- Diagnostic Tests
- Impairment Rating
- Claims
- Hospital Record for 03-06-03

**Information Submitted by Respondent:**

- Progress Notes