



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

May 4, 2005

Requestor

Cameron Jackson, DC
ATTN: Courtney
P.O. Box 890008
Houston, TX 77289

Respondent

Texas Mutual Insurance Company
ATTN: Ron Nesbitt
Fax#: (512) 404-3980

RE: Injured Worker: _____
MDR Tracking #: M2-05-1141-01
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 44 year-old male injured his back on ____ when the tractor he was driving hit a gas line and it exploded. He was thrown forward approximately ten feet and he landed on his back. He has been treated with therapy, medications, and epidural steroid injections.

Requested Service(s)

Proposed chronic pain management for 30 sessions

Decision

It is determined that there is no medical necessity for the proposed chronic pain management for 30 sessions.

Rationale/Basis for Decision

The medical information provided lacked documentation that chiropractic spinal manipulation was performed. The treating doctor's daily notes that chiropractic care was not rendered and that treatment was stopped. According to the AHCPDR guidelines, spinal manipulation was the recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. The British Medical Journal reported that spinal manipulation combined with exercise yielded the greatest benefit.

However, this treatment was not performed. Therefore, since the recommended efficacious treatment was not attempted on this patient, the requested chronic pain management program is premature and medically unnecessary.

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:dm

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 4th day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M2-05-1141-01

Information Submitted by Requestor:

- Letter of Medical Necessity
- Progress Notes
- Consult
- Functional capacity evaluation
- Procedures/Diagnostic Tests
- Requests/Denials/Claims

Information Submitted by Respondent:

- Letter of Medical Necessity
- Progress Notes
- Consult
- Procedures/Diagnostic Tests
- Claims