



# 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

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-6751.M2**

## NOTICE OF INDEPENDENT REVIEW DECISION

April 27, 2005

### Requestor

Nestor Martinez, DC  
ATTN: Gracie Diaz  
6660 Airline Drive  
Houston, TX 77078

### Respondent

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

RE: Injured Worker:  
MDR Tracking #: M2-05-1211-01  
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 Family Practice, by the American Board of Family Practice, Inc. licensed by the Texas State Board of Medical Examiners (TSBME) in 1978, 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 36 year-old male injured his back on \_\_\_ while lifting an object at his place of employment. He has been treated with medications, therapy, and epidural steroid injections.

### Requested Service(s)

Proposed work hardening x20 sessions

### Decision

It is determined that there is medical necessity for the proposed work hardening x20 sessions to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates an abnormal electromyogram and computed tomographic scan. He has received physical therapy and epidural steroid injection to treat his L4-5 spinal injury. He is showing improvement with this treatment. A work hardening program is appropriate to assist with a successful transition of returning to the work place. Therefore, the proposed work hardening x20 sessions 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: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 27<sup>th</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 #: M2-05-1211-01**

**Information Submitted by Requestor:**

- Progress Notes
- Functional capacity evaluation
- Work Hardening Program Notes
- Procedures
- Diagnostic Tests

**Information Submitted by Respondent:**

- Progress Notes
- Claims and Requests