

NOTICE OF INDEPENDENT REVIEW DECISION

July 25, 2005

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Requestor

Nestor Martinez, DC
ATTN: Gracie Diaz
6660 Airline Dr.
Houston, TX 77076

Respondent

Insurance Co. of the State of PA
c/o Flahive Ogden & Latson
ATTN: Kim Turko
Fax#: (512) 867-1733

RE: Injured Worker:
MDR Tracking #: M2-05-1838-01
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 61 year-old male injured his back on ___ while moving a box onto a dolly at his place of employment. He lost his balance and fell, landing on his back. He has been treated with medications and therapy.

Requested Service(s)

10 additional sessions of work conditioning

Decision

It is determined that there is medical necessity for the 10 additional sessions of work conditioning to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient progressed well throughout his entire treatment program. There is sufficient documentation provided to attest to this fact. Based upon the patient's improvement and most recent functional capacity evaluation, the treating doctor

requested 10 additional work condition sessions with the indication that once these were completed, the patient would return to work in his heavy job classification. National treatment guidelines allow for this type of treatment for this type of injury. There is sufficient clinical justification and appropriate documentation for the services requested. Therefore, the 10 additional sessions of work conditioning 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 25th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-1838-01

Information Submitted by Requestor:

- Progress Notes
- Diagnostic Tests
- Procedures
- Designated Doctors Evaluation
- Required Medical Examination
- Claims

Information Submitted by Respondent:

- Carrier's Position