

NOTICE OF INDEPENDENT REVIEW DECISION

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July 29, 2005

Requestor

Linh Vo, DC
505 N. Sam Houston Pkwy, Ste.170
Houston, TX 77060

Respondent

Lumbermens Mutual Casualty Co
Attention: Robert Josey
Fax: 512-346-2539

RE: Injured Worker: _____
MDR Tracking #: M2-05-1860-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (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

There is no medical record documentation received from the requestor or the respondent regarding this patient's medical condition or treatment provided.

Requested Service(s)

Work Hardening times 20 sessions

Decision

It is determined that the Work Hardening times 20 sessions is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Without medical record documentation provided, there is no evidence to support the prospective medical necessity of any proposed treatment. However, according to the pre-authorization documents submitted for review, there was a reference that indicated that the patient already failed a chronic pain management program (CPMP). This previously attempted program had within it the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the proposed work hardening program. Much of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any

meaningful way from the repeating treatments that already proved unsuccessful, the proposed work hardening program is not medically necessary.

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:gy

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 29th day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M2-05-1869-01

Information Submitted by Requestor:

- None

Information Submitted by Respondent:

- None