

NOTICE OF INDEPENDENT REVIEW DECISION

February 22, 2007

Bridgepoint I, Suite 300
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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Memorial Therapeutic Products
ATTN: Karina Romero
8200 Wednesday, #475
Houston, TX 77074

Respondent

Insurance Co. of the State of PA
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
504 Lavaca, Ste 1000
Austin, TX 78701

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M2-07-0516-01
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 Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC 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. 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 patient sustained a work related injury on ____ when he slipped and fell landing on his buttock and back area. This resulted in injury to his upper neck and lower back. Since his injury, he has received chiropractic care, therapy, medication, injection therapy, lumbar laminectomy fusion, post operative rehabilitation, home EMS unit and chronic pain management program.

Requested Service(s)

Spine lumbar-sacral orthosis

Decision

It is determined that the spine lumbar-sacral orthosis is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient is working with restrictions. The medical record documentation indicates an aggravation of pain and discomfort while working. The treating physician has prescribed a semi rigid lumbar support belt (M-SPINE) to be worn during increased activity only. The patient is entitled to treatment including DME that can assist with recovery from his injuries. Since the date of his injury, he has participated in a variety of treatments that have allowed him to recover to the point he could return to restricted duty work. The spine lumbar-sacral orthosis will allow the patient to perform his activities of daily living and to function in the work place environment with a minimal chance of re-aggravation.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 Department of Insurance, Division of Workers' Compensation, 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, DWC

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 22nd day of February 2007.

Signature of IRO Employee:
Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0516-01

Information Submitted by Requestor:

- Letter of Medical Necessity
- Operative Reports
- Patient Re-Evaluations by Dr. Raymond
- History and Physical Examination by Dr. Chang
- Reports of lower extremity electromyography studies and nerve conduction velocity studies.

Information Submitted by Respondent:

None