

NOTICE OF INDEPENDENT REVIEW DECISION

February 23, 2006

Requestor

Aurora Healthcare
ATTN: Jessica
3250 W. Pleasant Run Rd., Ste 130
Lancaster, TX 75146

Respondent

Fidelity & Guaranty Insurance Co.
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
505 W. 12th St.
Austin, TX 75701

Claim #:
Injured Worker:
MDR Tracking #: M2-06-0627-01
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 was involved in a motor vehicle accident while working for a rent-a-car service. This resulted in significant cervico-thoracic pain and stiffness radiating into the shoulder girdles bilaterally.

Requested Service(s)

Physical therapy 3X a week for 3 weeks

Decision

It is determined that the physical therapy 3X a week for 3 weeks is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The proposed care in this case meets statutory requirements¹ for medical necessity since it is reasonable to expect the patient will obtain more relief, promotion of recovery will be further accomplished and the employee's ability to return to or retain employment will be further enhanced.

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.

¹ Texas Labor Code 408.021

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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 23rd day of February 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name:

Tracking #: M2-06-0627-01

Information Submitted by Requestor:

- Letter of Medical Necessity
- Initial examination
- Table of disputed services
- Request for reconsideration
- Review decision letter

Information Submitted by Respondent:

- Letters from Dr. Moulton
- Chiropractic treatment notes
- Physical performance evaluation
- Request for reconsideration
- Review decision letter
- Prescription and Statement of Medical Necessity
- Letter from Attorneys
- Table of disputed services