

NOTICE OF INDEPENDENT REVIEW DECISION

March 8, 2006

Bridgepoint I, Suite 300  
5918 West Courtyard Drive • Austin, TX 78730-5036  
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Vaughn Brozek, DC  
ATTN: Stephanie  
5543 Ruff Snow Drive  
North Richland Hills, TX 76180

Respondent

Hartford Underwriters Ins. Co.  
ATTN: Barbara Sachse  
Fax#: 343-6836

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M2-06-0792-01  
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 she injured her neck and right shoulder while carrying a piece of plywood. The patient has been treated with medication and physical therapy.

Requested Service(s)

Therapeutic exercises 3 X per week for 4 weeks 6-8 units

Decision

It is determined that the Therapeutic exercises 3 X per week for 4 weeks 6-8 units are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient was found to have multiple injured areas. Diagnostic testing in the form of MRI and electrodiagnostic studies revealed evidence of C6 radiculopathy, some carpal tunnel syndrome, central disc protrusion and focal tear of the rotator cuff area. She was referred to an orthopedic surgeon who recommended continued physical therapy and rehabilitation for the shoulder and neck areas. She was referred for consideration of injections to the cervical area. Medication in the form of Lidoderm patches, Flexaril and Mobic and continuation of therapy was prescribed.

Since the patient did not start treatment until 11/04/2005; had multiple injured areas; evaluation by two other doctors concurred with her injuries; diagnostic testing confirmed her injuries; positive response to therapy to date; she was a candidate for cervical epidural steroid injections if she failed conservative treatment; and based on nation treatment guidelines in conjunction with this case's special circumstances, there is sufficient documentation to clinically justify therapeutic exercises 3 X per week for 4 weeks (6 units on each visit).

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.

M2-06-0792-01  
Page 3

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 8th day of March 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:**

**Tracking #: M2-06-0792-01**

**Information Submitted by Requestor:**

**None**

**Information Submitted by Respondent:**

- **Preauthorization Request**
- **Daily chart notes**
- **Follow up visit notes**
- **Report of MRI right shoulder and cervical spine**
- **Nerve conduction study**
- **Note from Dr. Klein**
- **Physical Demands Analysis**
- **Letter from patient**
- **Initial Evaluation**
- **Physical performance examination**
- **Orthopedic consultation.**