

NOTICE OF INDEPENDENT REVIEW DECISION

May 23, 2006

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Requestor

Brad Burdin, DC
ATTN: Jessica
9502 Computer Dr., #100
San Antonio, TX 78229

Respondent

New Hampshire Insurance Co. c/o SRS
ATTN: Mona
Fax#: (972) 807-4848

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-1222-01
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 attempting to move two boxes and felt a sharp stabbing pain in his back. The patient has been treated with chiropractic care, passive therapy, medication, and epidural steroid injection.

Requested Service(s)

Therapeutic procedures 97010 (1 unit), 97110 (1unit) for a total of 12 sessions at 3X a week for 4 weeks

Decision

It is determined that the therapeutic procedures 97110 (1unit) at 3X a week for 4 weeks is medically necessary to treat this patient's condition.

It is determined that the therapeutic procedures 97010 (1 unit) at 3X a week for 4 weeks is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has not had sufficient active therapy to date to have recovered from his injury. Therefore, the request for 97110 is medically necessary for the treatment of his on the job injury. After 3 times per week for 4 weeks is complete, a FCE needs to be obtained.

National treatment guidelines allow for treatment of this type of injury with documented subjective symptoms, objective findings and positive diagnostic testing. There is no guideline that allows for passive therapy such as 97010 some 6 months post injury. Therefore, therapeutic procedures 97010 (1 unit) at 3X a week for 4 weeks is not medically necessary

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.

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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 May 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-06-1222-01

Information Submitted by Requestor:

- Office notes from Dr. Burdin
- Office notes from Dr. Hirsch
- Office notes from Dr. Lampert
- Report of MRI of the lumbar spine
- Report of lumbar spine xrays
- Results of functional capacity examination
- N.I.T. initial evaluation
- Determination letters

Information Submitted by Respondent:

- Reconsideration
- Office notes from Dr. Burdin
- N.I.T. initial evaluation
- Office notes from Dr. Hirsch
- Results of the electrodiagnostic study
- Results of functional capacity examination
- Determination letters