

NOTICE OF INDEPENDENT REVIEW DECISION

May 26, 2006

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Requestor

San Antonio Spine & Rehab
ATTN: Lori
1313 SE Military Dr., Ste 107
San Antonio, TX 78214

Respondent

American Casualty Company
ATTN: Deborah Womak
600 N. Pearl St., Ste 1450
Dallas, TX 75201

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-1261-01
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 was transferring a patient from a recliner to a scooter and felt a pop in her low back and immediately felt pain in her low back and legs. The patient has been treated with chiropractic treatments as well as epidural steroid injections.

Requested Service(s)

12 sessions of physical therapy with CPT codes 97110, 97140, 97035, and G0283.

Decision

It is determined that the proposed 12 sessions of physical therapy with CPT codes 97110, 97140, 97035, and G0283 are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The proposed treatments have already been attempted and failed. The patient has elected to undergo surgical intervention. Therefore, the previously attempted treatments were not sufficiently beneficial and it would serve no purpose to repeat them. In addition, since the patient subsequently decided to have lumbar surgery, the proposed treatments are medically unnecessary.

Specifically in regard to therapeutic exercises: The active therapy may be performed in a clinic one-on-one, in a clinic in a group, at a gym, or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why continuing services were required to be performed one-on-one when current medical literature states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises."¹

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 Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18

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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 26th day of May 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-06-1261-01

Information Submitted by Requestor:

- **Table of Disputed Services**
- **Medical Dispute Resolution**
- **Decision Letters**
- **Initial evaluation**
- **Pre-Authorization Request**
- **Reconsideration for Physical Therapy**

Information Submitted by Respondent:

- **Letter to TMF**
- **CNA claim information**
- **Notice of Disputed Issues(s) and Refusal to Pay Benefits**
- **Medical Record Review**
- **Office notes from Dr. Earle**
- **Decision Letters**
- **Texas MedClinic notes**
- **Report of lumbar x-rays**
- **Chiropractor notes**
- **Pain Management Consultation**
- **Pain Management follow up visits**
- **Report of MRI of lumbar spine**
- **Report of nerve conduction study and electromyography**
- **Pain Management procedure notes**
- **Treatment progress notes**
- **Behavioral Health Assessment Report**
- **Office visits notes from South Texas Spinal Clinic**
- **Report of Functional Capacity Evaluation**
- **Disability Evaluation**
- **Report of Medical Evaluation**
- **Designated Doctor Report**
- **Subsequent evaluation – San Antonio Spine and Rehab**
- **Initial evaluations- San Antonio Spine and Rehab**