

NOTICE OF INDEPENDENT REVIEW DECISION

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

October 18, 2006

Requestor

Physical Medicine
ATTN: Carmen E.
26222 I-45 North
Spring, TX 77386

Respondent

Security Insurance Company
c/o Cunningham Lindsey
Fax#: (512) 452-7004

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-07-0002-01
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 TMF physician reviewer who is board certified in Internal Medicine, by the American Board of Internal Medicine, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1996, and who provides health care to injured workers. This is the same specialty as the treating physician. 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 fell approximately 20 feet, fracturing his left elbow and left heel. Treatment for this patient has included surgery, therapy, and epidural steroid injections.

Requested Service(s)

Physical medicine treatments: 97010 hot packs, 97032 electrical stimulation, 97035 ultrasound, and 97110 therapeutic exercises.

Decision

It is determined that the physical medicine treatments: 97010 hot packs, 97032 electrical stimulation, 97035 ultrasound, and 97110 therapeutic exercises are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Given this patient's known impingement syndrome of the left shoulder, prior left ulnar fracture, and surgeries including a lumbar fusion, these minimally invasive services are indicated in an attempt to treat the patient's symptoms and to increase the patient's range of motion.

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 18th day of October 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0002-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Office notes from Dr. Weiss
- Daily progress reports
- Reports of range of motion
- ESWT procedure report
- DME prescription and letter of medical necessity
- History and Physical by Dr. Roman
- Letter of Medical Necessity from Dr. Jennings
- History and Physical by Dr. Jennings
- Electrodiagnostic studies
- History and Physical by Dr. Ghadially
- Office notes from Dr. Ghadially
- Report of CT of the left ankle and foot
- Request for reconsideration
- Review determinations
- Orthopedic surgeon review by Dr. Cyr
- Review by Dr. Strizak