

NOTICE OF INDEPENDENT REVIEW DECISION

October 24, 2006

Bridgepoint I, Suite 300
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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Trinity Injury & Pain Center
ATTN: Dr. Anderson
3821 Ross Ave.
Dallas, TX 75204

Respondent

New Hampshire Insurance Co.
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
504 Lavaca, Ste 1000
Austin, TX 78701

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M2-07-0041-01
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 ____, which occurred while he was riding in a van. This resulted in a lumbar, thoracic and cervical sprain/strain. Since his injury he has had chiropractic care, passive therapy, active rehabilitation, psychotherapy, and functional capacity evaluations (FCE). MRI's were essentially unremarkable with the exception of a herniated nucleus pulposus at T10-11.

Requested Service(s)

Work hardening 120 units

Decision

It is determined that the work hardening 120 units is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient was placed at maximum medical improvement by a designated doctor on 08/31/2006 and given a zero percent impairment rating. At that time the doctor also ordered another FCE that was determined to be valid and reliable. On that date his physical demand level (PDL) indicated a sedentary-light physical demand level above the waist and the light physical demand level for below the waist. Treatment guidelines allow for a work hardening program. This patient has completed appropriate treatment to date and has not attained the physical demand level he had prior to his on the job injury. He has not progressed to the point where he can return to his previous occupation. Given the fact that the requirements for his occupation are heavy PDL, he needs the work hardening program to give him the best chance of once again reaching heavy PDL. Therefore, the proposed 120 units of work hardening are medically necessary to treat this patient's condition and allow him the best opportunity to return to his former employment.

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 24th day of October 2006.

Signature of IRO Employee:
Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0041-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Letter from attorneys
- UR review determination
- Reconsideration of adverse determination
- Report of Medical Evaluation
- Review of medical history and physical exam
- PEER review results
- Table of disputed services
- TCM Utilization Review Report