

NOTICE OF INDEPENDENT REVIEW DECISION

November 16, 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

\_\_\_\_\_

Respondent

American Zurich Insurance Company  
c/o Flahive, Ogden & Latson  
ATTN: Katie Foster  
504 Lavaca, Ste 1000  
Austin, TX 78701

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-07-0182-01  
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 carrying a vacuum machine that was strapped to her shoulders. This resulted in severe pain in her shoulders. She was seen by her treating doctor on 08/09/06 for evaluation and initiation of treatment. The patient has been treated with medication, chiropractic care, and physical therapy.

Requested Service(s)

Physical therapy sessions x 18, 97110, G0283, 97124, and 97035

Decision

It is determined that the physical therapy, 97110 (2 or 3 units per session) for a total of 12 sessions is medically necessary to treat this patient's condition.

It is determined that the physical therapy sessions G0283, 97124, and 97035 are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

National treatment guidelines allow for this type of treatment for this type of injury. However, since it has now been over three months since her injury, there is no medical necessity for passive therapy. Therefore the codes G0283, 97124, and 97035 are not medically necessary to treat her injury. Active therapy, i.e. code 97110, would be appropriate for her continuing problems.

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: 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 16th day of November 2006.

Signature of IRO Employee:  
Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:** \_\_\_\_

**Tracking #:** M2-07-0182-01

**Information Submitted by Requestor:**

None

**Information Submitted by Respondent:**

None

**Information Submitted by Treating Doctor**

- **Valley Spine Medical Center Daily Treatment Notes**
- **Follow Up Evaluation**
- **Initial Evaluation**
- **Initial Medical Narrative Report**