

NOTICE OF INDEPENDENT REVIEW DECISION

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January 30, 2007

Requestor

Injury 1 Treatment Center  
ATTN: James Odom  
5445 La Sierra Dr., #204  
Dallas, TX 75231

Respondent

American Home Assurance Company  
c/o ARCMI  
ATTN: Raina Robinson  
P.O. Box 115114  
Carrollton, TX 75011-5114

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-07-0632-01  
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 Family Practice, by the American Board of Family Practice, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1980, 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 she was hit from behind by a shopping cart that resulted in an injury to the right knee, leg and lower back. An MRI did not reveal a surgical injury to the knee and as a result, physical therapy was ordered.

Requested Service(s)

Physical therapy 3 X weekly for a total of 12 visits

Decision

It is determined that physical therapy 3 X weekly for a total of 12 visits is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Physical therapy was originally ordered for this patient and was discontinued due to the patient's complaint of worsening symptoms. She still had 4 treatments remaining on previously authorized therapy. It would be appropriate to finish these and then assess the patient's tolerance and benefit prior to authorizing further treatment.

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 30th day of January 2007.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

Patient Name: \_\_\_\_

Tracking #: M2-07-0632-01

**Information Submitted by Requestor:**

- Patient Information Sheet
- Table of Disputed Services
- Physical Therapy Pre-Authorization Request
- Letter of determination
- Reconsideration: Physical Therapy Pre-Authorization Request
- Physical Therapy Evaluation
- History and Physical by Dr. Crockett
- Report of MRI of the right knee
- History and Physical by Dr. Brewer
- History and Physical by Dr. Hair
- Office notes from Dr. Kadoko
- Office notes from Dr. Crockett

**Information Submitted by Respondent:**

- Independent Review Organization Summary
- Letter of determination
- Office notes from Concentra
- Office notes from Dr. Kadoko
- Report of MRI of the right knee
- Physical therapy notes
- History and Physical by Dr. Crockett
- Physical therapy evaluation
- Office notes from Dr. Crockett
- Initial Behavioral Medicine Evaluation
- Individual Psychotherapy Notes
- Nerve Conduction/EMG study
- Table of disputed services
- Physical Therapy Pre-Authorization Request
- Reconsideration: Physical Therapy Pre-Authorization Request
- Report of MRI of the left shoulder