

NOTICE OF INDEPENDENT REVIEW DECISION

February 8, 2007

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Requestor

Respondent

Old Republic Insurance Company
c/o Gallagher Bassett
ATTN: Neal Moreland
Fax#: (512) 732-2404

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M2-07-0702-01
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 he was rear-ended by an 18-wheeler causing him to be thrown back and hit his head on the back of the cab then he went forward and hit his face on the steering wheel. This resulted in injury to his neck, low back, right shoulder, and a broken tooth. He has been treated with physical therapy, epidural steroid injections, surgery, and participation in a work hardening program.

Requested Service(s)

Physical therapy 3 times a week for 2 weeks

Decision

It is determined that the physical therapy 3 times a week for 2 weeks is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an epidural steroid injection. While the proposed treatments may have a diminished benefit at this late date, they were nevertheless indicated at the time the original preauthorization was made, and after being prescribed by the operative doctor on 11/21/06. Therefore, the proposed treatments fulfilled statutory requirements¹ for medical necessity since they would have likely helped relieve pain, promote recovery and enhance the employee's ability to return to 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.

¹ Texas Labor Code 408.021

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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: 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 8th day of February 2007.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0702-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Office notes from Dr. Saqer
- Office notes from Dr. Reynolds
- Patient Daily Log Sheets
- Report of Functional Abilities Evaluation
- Work Hardening Weekly Team Conference
- Psychological Issue and Symptoms Checklist
- Nassau Bay Rehab exercise sheets
- Outpatient Daily Physical/Occupational Medicine Progress Notes
- Procedure Reports
- Request for reconsideration
- NBC Healthcare Center Daily Notes Reports
- Work Hardening Psychotherapy Group notes
- Decision notices
- Designated Doctor Evaluation
- Report of weight bearing MRI of the C Spine
- Occupational Therapy Daily Progress Notes
- Operative Notes
- Computerized muscle testing and range of motion
- Office notes from Dr. Suhail Al-Sahli
- Report of CT of the right shoulder
- Required Medical Evaluation
- Review of Medical Records
- History and Physical by Dr. Cole
- PEER review by IMED Inc.
- Insurance Carrier's Detail