



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

PREVAILING PARTY DETERMINATION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier

Requestor's Name and Address:

Monarch Pain Care Center
5151 Katy Fwy, Suite 305
Houston, TX 77007

MDR Tracking No.: M5-05-2863-01

Claim No.:

Injured Employee's Name:

Respondent's Name and Address:

Liberty Insurance Corp, Box 28

Date of Injury:

Employer's Name:

Insurance Carrier's No.:

PART II: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), the Division assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the requestor and respondent.

Consistent with the requirements in Rule 133.308, the Division has reviewed the IRO decision and determined:

- The requestor is the prevailing party.
 The respondent is the prevailing party.

PART III: ADDITIONAL INSTRUCTIONS

The parties are instructed to review the IRO decision and take appropriate action. For any services that may have been found to be medically necessary, the insurance carrier is instructed to process those services through their bill review and payment processes, including issuing any additional amounts due consistent with the established fee guidelines. If the requestor was the prevailing party, the carrier must refund the amount of the IRO fee within to the requestor within 30-days of receipt of this order.

Issued by:

Donna Auby

9-6-05

Authorized Signature

Typed Name

Date of Order



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NOTICE OF INDEPENDENT REVIEW DECISION

August 30, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-05-2863-01
IRO Certificate #: IRO4326

The TMF Health Quality Institute has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered 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. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 41 year old male injured both knees on ___ in a work related event. He was treated with medications and therapy.

Requested Service(s)

Work hardening program for dates of service 02/07/05 through 03/23/05

Decision

It is determined that the work hardening program from 02/07/05 through 03/23/05 was not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The records indicated that the patient was injured on the job on ___ when both knees were injured when they were crushed between two pieces of heavy steel molding that were being moved by a crane. He was evaluated and a treatment program was begun. Lower extremity EMG was essentially normal. The functional capacity evaluation was performed and it was determined that he was unable to return to work in the position of a laborer because the position is classified as heavy. Apparently, surgical intervention was not necessary. He was referred for a work hardening evaluation; however, the medical record documentation does not substantiate the medical necessity for a work hardening program versus a work conditioning program.

There was no psychological evaluation or any other documentation that would clinically require the intense, multi-disciplinary program of work hardening. This patient did not meet the national treatment guidelines for participation in a work hardening program.

Sincerely,

A handwritten signature in black ink that reads "Gordon B. Strom, Jr." in a cursive style.

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Attachment

Information Used by TMF in Decision

Patient Name: ____

TWCC ID #: M5-05-2863-01

Medical record documentation provided:

- **Work Hardening Notes**
- **Progress Notes**
- **Peer Reviews**
- **Diagnostic Tests**
- **Claims and Requests**