



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South • Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

January 27, 2005

Requestor

Bexar County Healthcare Systems
ATTN: _____
201 S. Madison Ave.
Dallas, TX 75208

Respondent

Zurich American Insurance Company
ATTN: _____
505 W. 12th Street
Austin, TX 78701

RE: Injured Worker:
MDR Tracking #: M2-05-0293-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) 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 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. 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 43 year-old female injured her back on ____ while lifting a 50 pound pot filled with potatoes. She reported that as she was lifting it, she felt her back slip and immediately felt pain in her back shooting down her right leg. She has been treated with medications and therapy.

Requested Service(s)

Proposed chronic behavioral pain management times ten sessions

Decision

It is determined that there is medical necessity for the proposed chronic behavioral pain management times ten sessions to treat this patient's medical condition.

Rationale/Basis for Decision

Texas statutes¹ authorize treatment that can be reasonably expected to offer relief, promote recovery or enhance the employee's ability to return to or retain employment. In this case, the proposed 10 sessions of chronic behavioral pain management offer the patient a reasonable opportunity to relieve her pain and reduce

¹ Texas Labor Code 408.021

her reliance on pain medication. Therefore, the proposed chronic behavioral pain management times ten sessions are medically necessary to treat this patient's medical condition.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

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 Workers' Compensation Commission, 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,

Director of Medical Assessment

Attachment

cc: _____, Injured Worker
Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

<p>In accordance with Commission 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 27th day of January 2005.</p> <p>Signature of IRO Employee:</p> <p>Printed Name of IRO Employee:</p>

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0293-01

Information Submitted by Requestor:

- Psychological Evaluation
- Treatment Notes

Information Submitted by Respondent:

- Progress Notes
- Carrier's Position