



# Texas Medical Foundation

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## NOTICE OF INDEPENDENT REVIEW DECISION

February 9, 2005

### Requestor

Texas Health  
ATTN: Clara Pou  
5445 La Sierra Dr., #204  
Dallas, TX 75231

### Respondent

Travelers Indemnity Company  
ATTN: Jeanne Schafer  
Fax#: (512) 347-7870

RE: Injured Worker:  
MDR Tracking #: M2-05-0653-01  
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 46 year-old female injured her bilateral wrist on \_\_\_ while on the job. She has been diagnosed with carpal tunnel syndrome. She has been treated with therapy and surgery.

### Requested Service(s)

Proposed 10-day chronic pain management program

### Decision

It is determined that there is medical necessity for the proposed 10-day chronic pain management program to treat this patient's medical condition.

### Rationale/Basis for Decision

Medical record documentation indicates this patient has received extensive therapy; however, her long-term response to treatment has been less than satisfactory. National treatment guidelines confirm that patients with chronic pain syndrome are best treated in an integrated interdisciplinary program. Although she has received treatment from a variety of providers, there has never been an aggressive, comprehensive treatment with a coordinated group of health care providers like what would be available in a chronic pain management program. Therefore, the proposed 10-day chronic pain management program is appropriate and 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,

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

GBS:dm

Attachment

cc: \_\_\_\_\_, Injured Worker  
Program Administrator, Medical Review Division, TWCC

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 9<sup>th</sup> day of February 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for TWCC Review**

**Patient Name:**

**TWCC ID #: M2-05-0653-01**

**Information Submitted by Requestor:**

- Requests for Authorization
- Progress Notes
- Occupational Therapy Evaluation
- Functional capacity evaluation
- Behavioral Medicine Consult
- Consult
- Magnetic resonance imaging

**Information Submitted by Respondent:**

- Claims