



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

March 9, 2005

Requestor

North Texas Pain Recovery Center
ATTN: Paula Arredondo
6703 West Poly Webb Road
Arlington, TX 76016

Respondent

Royal Indemnity Company
c/o Royal & Sun Alliance
ATTN: Marshall S. Wiggins
Fax#: (512) 452-7004

RE: Injured Worker:
MDR Tracking #: M2-05-0711-01
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 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 1978, 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 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 52 year-old female injured her left arm and shoulder on ___ when she picked up a 40-pound bag of groceries and hit her arm on the cart. She has been treated with therapy, medications, and steroid injections.

Requested Service(s)

Proposed 240 hours of chronic pain management program

Decision

It is determined that there is no medical necessity for the proposed 240 hours of chronic pain management to treat this patient's medical condition.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. However, for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time period. Medical record documentation indicates this patient has been treated with multiple modalities including therapy, medications, steroid injections, and manipulation for over 1 year with minimal improvement and her electromyogram is negative. If treatment does not produce the expected positive results, it is not reasonable to continue that course of treatment. There is no evidence to support the need for monitored therapy when a home exercise program can provide the same benefit and it can be performed by the patient on a daily basis. Therefore, the proposed 240 hours of chronic pain management is not 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

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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 9th day of March 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M2-05-0711-01

Information Submitted by Requestor:

- Work Hardening Program Notes
- Progress Notes
- Response to Peer Review
- Requestors Notes

Information Submitted by Respondent:

- Progress Notes
- Required Medical Exam
- Treatment Record
- FUNCTIONAL CAPACITY EVALUATION
- Psychological Screening Notes
- Designated Doctor Evaluation
- Peer Review
- Physical Therapy Notes
- Claims