

NOTICE OF INDEPENDENT REVIEW DECISION

August 1, 2005

Barton Oaks Plaza Two, Suite 200
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Requestor

Pain & Recovery Clinic c/o Bose Consulting
ATTN: Mary Ann Lister
P.O. Box 550496
Houston, TX 77255

Respondent

Travelers Property & Casualty
ATTN: Jeanne Schafer
Fax#: (512) 347-7870

RE: Injured Worker: _____
MDR Tracking #: M2-05-2058-01
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 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 Anesthesiology, by the American Board of Anesthesiology, Inc, licensed by the Texas State Board of Medical Examiners (TSBME) in 1989, 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 24 year-old male injured his back, chest and head on ___ when a metal gutter struck an electrical line causing an electrocution injury. He has been treated with therapy and medications.

Requested Service(s)

Chronic pain management program x 20 sessions

Decision

It is determined that there is no medical necessity for the chronic pain management program x 20 sessions to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates numerous methods of treatment have been performed and that he reached his maximum medical improvement on 03/16/05. Diagnostic testing indicates a normal electrocardiogram and electroencephalogram, negative

electromyogram/nerve conduction velocity and 2 bulging discs on the magnetic resonance imaging that are not herniated. Further treatment is not medically indicated or appropriate given this patient's history of failed treatment and negative diagnostic testing. Therefore, the chronic pain management program x 20 sessions 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
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 1st day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: