

NOTICE OF INDEPENDENT REVIEW DECISION

August 8, 2005

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

Requestor

Gwen Whigham, DC
2646 S. Loop West #290
Houston, TX 77054

Respondent

Texas Mutual Insurance Co.
ATTN: Deborah Bailey
(512) 224-3980

RE: Injured Worker:
MDR Tracking #: M2-05-2066-01
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 37 year-old male injured his back with radiating pain into his right side on ___ when he slipped on a wet floor. He has been treated with medications and therapy.

Requested Service(s)

Chronic pain management program x20 sessions

Decision

It is determined that there is no medical necessity for the chronic pain management program x20 sessions to treat this patient's medical condition.

Rationale/Basis for Decision

Current medical literature state, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care."¹ A systematic review of the

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.² And finally, medical record documentation does not indicate the types of therapies and/or treatments attempted during the time period immediately preceding the treatment in question and no indications of what benefit or failure these therapies and/or treatments may have provided. Therefore, the chronic pain management program x20 sessions are 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

² Karjalaniene K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Review 2000;2.

M2-05-2066-01
Page 3

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 8th day of August 2004.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Used by TMF in Decision

Patient Name:

TWCC ID #: M2-05-2066-01

Medical record documentation provided:

- Progress Notes
- Required Medical Examination
- Diagnostic Tests
- Treatment Notes
- Impairment Rating
- Claims