

NOTICE OF INDEPENDENT REVIEW DECISION

September 27, 2005

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Requestor

Cameron Jackson, DC  
ATTN: Courtney  
P.O. Box 890008  
Houston, TX 77289

Respondent

Texas Mutual Insurance Co.  
ATTN: Debra Bailey  
Fax#: (512) 224-3980

RE: Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-05-2214-01  
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 patient injured herself on the job on \_\_\_\_\_. The patient is experiencing left lower extremity radiculopathy. She has undergone multiple alternative modes of therapy including physical therapy and epidural injections.

Requested Service(s)

Chronic pain management for 5 times a week for 6 weeks

Decision

It is determined that there is no medical necessity for the chronic pain management for 5 times a week for 6 weeks to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation indicates this patient was injured in a work related accident in which she fell in the restroom at work due to wet, soapy tiles. She has received aggressive treatment and appropriate diagnostic testing was ordered that confirmed the significance of her

Rationale/Basis for Decision

injury. It was determined she is not a surgical candidates at this time due to psychological issues and chronic pain management was recommended. There is sufficient documentation to confirm an ongoing chronic pain syndrome; however, there has not been a trail period to assess and monitor the patient's response and benefit from such a program. National treatment guidelines do not allow for an entire 30 session of chronic pain management without a trial period. Therefore, the chronic pain management for 5 times a week for 6 weeks 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 27th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: