

NOTICE OF INDEPENDENT REVIEW DECISION

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

September 30, 2005

Requestor

Respondent

Webb County
ATTN: Robert Josen
P.O. Box 162443
Austin, TX 78716

RE: Injured Worker:
MDR Tracking #: M2-05-2235-01
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 Pain Management, 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 patient was injured on ___ in a work related injury. Based on the documentation provided, the patient has been treated with psychotherapy sessions, physical therapy, chiropractic care, and injection therapy.

Requested Service(s)

Chronic pain management program 30 sessions and individual psychotherapy X8 additional sessions.

Decision

It is determined that the chronic pain management program 30 sessions and individual psychotherapy X8 additional sessions are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based on the documentation provided, this patient has already had 16 previous psychotherapy sessions without any success. It is unlikely that she would respond to more sessions based on prior experiences. In addition, since the patient complains of 2/10 pain, and her major concern is anxiety, a multidisciplinary program is not warranted.

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: 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 30th day of September 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Attachment

Information Used by TMF in Decision

Patient Name: M2-05-2235-01

TWCC ID #:

Medical record documentation provided:

- **Claims**
- **Notice of Pre-Authorization**
- **Letter for Harris & Harris dated August 23, 2005**