

NOTICE OF INDEPENDENT REVIEW DECISION

November 15, 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

Texas Health
ATTN: James Odom
5445 La Sierra Dr., #204
Dallas, TX 75231

Respondent

Zurich American Ins. Co. c/o Broadspire
ATTN: Rick Jacobs
P.O. Box 701809
Dallas, TX 75370

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-05-2304-01
IRO Certificate #: IRO4326

TMF Health Quality Institute (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Division of Workers' Compensation (DWC) has assigned the above referenced case to TMF for independent review in accordance with DWC 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. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and the provider, the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO. 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 sustained an injury on _____. He was putting a bed together and the headboard fell and struck him from behind resulting in a spinal injury to his low back. He was initially seen by the company doctor. He continued to have problems and he changed doctors in September. An evaluation was performed and an aggressive treatment program was begun. A lumbar MRI revealed a disc problem. His treatment program had included passive and active physical rehabilitation, multiple diagnostics, lower level behavioral health treatment, and 20 sessions of a multidisciplinary chronic pain program.

Requested Service(s)

10 additional sessions of chronic pain management

Decision

It is determined that 10 additional sessions of chronic pain management are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has already received passive and active therapy and there is a lack of improvement revealed on his comparative analysis on his 18th day (07/08/2005). There was no improvement in 6 of the 11 measured items, reduction in only 2 of the 11 and increase in 3 of the 11. This assessment indicates that there was minimal, if any significant benefit derived from this program. The patient had received an intense treatment program for over one year that included 20 sessions of a chronic pain management program and there is not sufficient documentation to warrant 10 additional sessions.

This decision by the IRO is deemed to be a DWC decision and order.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 Department of Insurance, Division of Workers' Compensation, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

M2-05-2304-01
Page 3

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, DWC

In accordance with Division 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 15th day of November 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: