



NOTICE OF INDEPENDENT REVIEW DECISION

October 14, 2005

Barton Oaks Plaza Two, Suite 200  
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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

**Amended Letter: October 20, 2005**

Requestor

Pinnacle Pain Management  
ATTN: Michael Soderstrom  
2100 Bering St., Ste 809  
Houston, TX 77057

Respondent

Texas Mutual Ins. Company  
ATTN: Latrice Giles  
Fax#: (512) 224-3899

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR#: M2-05-2332-01  
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 Department of Workers' Compensation (DWC) 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 35 year old male sustained a work related injury on \_\_\_\_ when he hurt his back after hooking up an air compressor.

Requested Service(s)

10 sessions of chronic pain management

Decision

It is determined that 10 sessions of chronic pain management is not medically indicated to treat this patient's condition

Rationale/Basis for Decision

Based on the information provided, it is unknown what kinds of therapies and/or treatments have already been attempted on this patient. There is no documentation as to what was beneficial and what was not beneficial, whether or not spinal manipulation was ever performed, and whether the proposed chronic pain management (CPMP) would be different from what has already been tried. The medical provider performing the injection therapy on the patient reported that the patient was responding from the injection therapy protocols being performed. However, the behavioral assessment provider indicated that the patient remained essentially unchanged from the procedures. Therefore, due to the conflicting information on the limited medical record documentation, the CPMP is not medically indicated.

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.

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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,

A handwritten signature in black ink, appearing to read "Gordon B. Strom, Jr.", written in a cursive style.

Gordon B. Strom, Jr., MD  
Director of Medical Assessment

GBS:dm

Attachment

cc: \_\_\_\_\_, Injured Worker  
Program Administrator, Medical Review Division, DWC

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 14th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name: \_\_\_\_

DWC ID #: M2-05-2332-01

**Information Submitted by Requestor:**

None

**Information Submitted by Respondent:**

- Letter from Texas Mutual
- Doctor office notes
- Initial evaluation
- Designated doctor evaluation
- Assessment from Pinnacle Pain Management Solutions
- Follow-up note
- Operative Report