

NOTICE OF INDEPENDENT REVIEW DECISION

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October 14, 2005

Requestor

Respondent

American Home Assurance Co. c/o ARCFI
ATTN: Raina Robinson
P.O. Box 115114
Carrollton, TX 75011

RE: Injured Worker:
MDR Tracking #: M2-06-0008-01
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 Orthopedic Surgery, by the American Board of Orthopaedic Surgery Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1969, 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 sustained a work related injury on 09/__/2003 when he was lifting a tire and felt a sharp discomfort in the right upper quadrant. An MRI performed on 09/26/2003 revealed evidence of a posterior lower lumbar fusion but no acute disease. The patient complains of chronic right flank pain. The patient has received chiropractic care as well as an evaluation by neurosurgery. The patient has most recently been under the care of Tom G. Mayer, MD (Orthopedics & Rehabilitation) for 22 sessions of chronic pain management.

Requested Service(s)

22 sessions of chronic pain management

Decision

It is determined that 10 sessions of chronic pain management are medically indicated to treat this patient's condition. However, 12 sessions of chronic pain management are not medically indicated.

Rationale/Basis for Decision

This patient has not resolved his chronic pain syndrome. The multi-disciplinary approach of a pain management program has been shown to provide the best results in restoration of function. A ten visit program followed by concurrent review is the most reasonable treatment. The program includes PT, OT, occupational medicine, vocational training, and psycho-social support. It would be beneficial for the patient to undergo 10 visits.

This decision by the IRO is deemed to be a TWCC 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 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

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 14th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M2-06-0008-01

Information Submitted by Requestor:

- Request and denial rationale
- TWCC BRC Ruling
- Medical records
- Testing and radiology

Information Submitted by Respondent:

- IRO summary
- Denial letters
- Report of injury
- Claims
- Investigative reports
- Treatment notes
- Testing and evaluations
- Therapy notes