

NOTICE OF INDEPENDENT REVIEW DECISION

December 6, 2005

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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Healthtrust
ATTN: Courtney
P.O. Box 890008
Houston, TX 77289

Respondent

Old Republic Insurance Co. c/o
Downs & Stanford
ATTN: W. Jon Grove
2001 Bryan St., Ste 4000
Dallas, TX 75201

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0218-01
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 multiple injuries to his right shoulder, neck, low back, right knee, and jaw on ___ when a soda pallet weighing approximately 600 pounds was dropped on him and he fell on his right side. Treatment has included medication, steroid injections, facet injections, nerve blocks, radiofrequency thermal coagulation, chiropractic treatments, physical therapy, surgical treatment, and work hardening.

Requested Service(s)

Chronic pain management 5 times a week for 6 weeks (30 sessions)

Decision

It is determined that the chronic pain management 5 times a week for 6 weeks (30 sessions) is not medically necessary at this time to treat this patient's condition. However, 10 sessions would be medically necessary.

Rationale/Basis for Decision

This patient was placed at statutory maximum medical improvement and given a 9% impairment rating by a designated doctor. There is sufficient documentation of subjective and objective finding to confirm his long standing chronic pain syndrome and this patient does in fact need a chronic pain management program. However, national treatment guidelines do not allow for approval of the entire 30 sessions of the program without a trial period to assess and monitor the patient's response, attendance, and benefit from the program. Therefore, 10 sessions would be medically necessary with evaluation of patient's response, attendance, and benefit from the program.

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.

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: Kirk D. Brady, 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 6th day of December 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: