

NOTICE OF INDEPENDENT REVIEW DECISION

December 16, 2005

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

Requestor

Pinnacle Pain Management
ATTN: Michael Soderstrom
2100 Bering, Suite 809
Houston, TX 77057

Respondent

Texas Mutual Ins. Co.
ATTN: Latrice
Fax#: (512) 224-7094

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0255-01
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 a work-related injury in a motor vehicle accident. Over the course of treatment there were diagnostic testing in the form of x-rays, MRIs, EMGs, and nerve conduction studies that revealed positive findings. The patient was treated with medication, chiropractic care, therapy, psychotherapy, and lumbar epidural steroid injections.

Requested Service(s)

10 sessions of chronic pain management

Decision

It is determined that 10 sessions of chronic pain management are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient was seen by a designated doctor and found him to have reached maximum medical improvement and awarded an impairment rating of 10%. In spite of all this, he continued to experience an ongoing chronic pain syndrome of over 10 months in duration. He has had a significant amount of treatment to date but continues to experience significant difficulties. There continues to remain sufficient subjective symptoms, objective findings, and psychosocial issues present that have not been adequately addressed with the treatment he has received to date. There continues to be issues with inability to sleep/rest, anxiety, depression, high levels of pain, and continued medication usage. In addition he has not recovered sufficiently to be allowed to return to work. Since he has essentially failed primary and secondary levels of care, the 10 sessions of chronic pain management are appropriate.

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

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 16th day of December 2005.

Signature of IRO Employee:
Printed Name of IRO Employee: