

NOTICE OF INDEPENDENT REVIEW DECISION

January 31, 2006

Requestor

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

Respondent

Liberty Insurance Corporation
ATTN: Carolyn Guard
Fax#: (574) 258-5349

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0557-01
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 on ___ while performing his customary duties as a driver/warehouse worker. He was walking between trucks when he stumbled over a piece of concrete and twisted his left knee. The patient was treated with intensive therapy, surgery, and post-operative physical therapy.

Requested Service(s)

Biofeedback psychophysiological profile assessment with four modalities (EMG, PNG, TEMP and SC/GSR).

Decision

It is determined that the biofeedback psychophysiological profile assessment with four modalities (EMG, PNG, TEMP and SC/GSR) is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

It has been nearly one year since the patient's on the job injury. He has undergone an intensive therapy program, surgical intervention and post surgical rehabilitation program. He continues to complain of a subjectively high pain level that is not supported in the medical record documentation by objective findings. The Biofeedback psychophysiological profile assessment with four modalities (EMG, PNG, TEMP and SC/GSR) is not medically necessary as the injured worker is not manifesting psychological symptoms that would benefit from biofeedback treatment.

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 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 31st day of January 2006.

Signature of IRO Employee:
Printed Name of IRO Employee: