

NOTICE OF INDEPENDENT REVIEW DECISION

March 28, 2006

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

Requestor

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

Respondent

City of Dallas c/o Harris & Harris
ATTN: Robert Josey
P.O. Box 162443
Austin, TX 78716

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-0756-01
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 ____ to her cervical spine and her left shoulder while performing her customary duties as a customer service supervisor. She stated that the repetitive motion of having to shift positions of her monitor and chair to avoid the glare from the glass wall behind her caused her injury. Electro-diagnostic testing revealed radiculopathy and an MRI revealed multi-level disc degeneration, minimal bulges, and slightly narrowed left foramen changes at C5 and C6. She was seen on 12/02/2005 for the initial behavioral consultation in which she reported her intermittent elevations of pain to be 8/10 and interference pain poses in regards to normal activities and with her ability to work at 7/10.

Requested Service(s)

(1) Session of (90901) Biofeedback psychophysiological assessment to consist of 4 modalities (PNG, TEMP, EMG, and SC/GSR)

Decision

It is determined that the (1) session of (90901) Biofeedback psychophysiological assessment to consist of 4 modalities (PNG, TEMP, EMG, and SC/GSR) is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

As a result of the patient's injury, she received treatment that exceeds any national treatment guideline. She was placed at MMI and given a 9% impairment rating on 10/10/2002. With an impairment rating of 9% there is a chance that additional treatment on an as needed basis might be needed but nothing of a scheduled extended treatment plan was warranted. She received treatment throughout 2005 at times on a weekly basis. This exceeds any reasonable guideline.

In conclusion, the medical record documentation does not specifically associate the patient's repetitive injury with any type of psychological problem that would require the requested testing. Therefore the requested services are not medically necessary for the treatment of this patient's condition.

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,



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 28th day of March 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name:

Tracking #: M2-06-0756-01

Information Submitted by Requestor:

- **Table of Disputed services**
- **Requestor's Position Regarding Pre-authorization of Behavioral Health Services**
- **Behavioral Health Biofeedback PPA Pre-authorization Request.**
- **Determination notices**
- **Reconsideration Process**
- **Behavioral Health Treatment Reconsideration Preauthorization Request.**
- **Reconsideration: Request for Behavioral Health Treatment**

Information Submitted by Respondent:

None

Information Submitted by Treating Physician:

- **Initial Behavioral Medicine Consultation**
- **Addendum**
- **Determination notices**
- **Reconsideration Process**
- **Electromyographic Report and Summary of Nerve Conduction Velocity Studies**
- **Initial Neurological Consultation**
- **Report of MRI Scan-Cervical Spine**
- **Functional Capacity Testing Report**
- **Report of Impairment (Designated Doctor Examination)**
- **Letter from Dr. Cunningham**
- **Chiropractic Office Notes**
- **Daily Notes Report**