

NOTICE OF INDEPENDENT REVIEW DECISION

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April 21, 2006

Requestor

South Texas Chronic Pain Institute
ATTN: Yolanda Herrea
2503 Buddy Owens
McAllen, TX 78504

Respondent

Texas Mutual Insurance
ATTN: Latrice Giles
Fax#: (512) 224-7094

RE: Claim #:
Injured Worker: _____
MDR Tracking #: M2-06-0890-01
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 TMF physician reviewer who is board certified in Pain Management, by the American Board of Anesthesiology, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1990, 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 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 ___ resulting in injury to his right shoulder and cervical spine. He has been diagnosed with rotator cuff tear and right C-7 radiculopathy with C6-7 disc bulge, and secondary anxiety and depression. He has undergone right shoulder surgery, cervical spine injections including epidural spinal injections, physical therapy, and medication management, and now has completed 10 days of Daily Chronic Pain Management Program (CPMP), and is being referred for an additional 10 days of the program.

Requested Service(s)

Chronic pain management X 10 sessions

Decision

It is determined that the chronic pain management X 10 sessions is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had minimal or no change in pain complaints or symptoms, and only minimal objective change in measurable depression and anxiety. On the initial follow up visit following completion of the 10 day treatment course, the treating physician recommended a neurologist evaluation and a referral was made for additional cervical spine injection therapy. In addition, there is no documentation of medication tapering or medication efficacy noted, and the patient remains on Effexor and Ultram.

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 21st day of April 2006.

Signature of IRO Employee: Printed Name of IRO Employee: