

NOTICE OF INDEPENDENT REVIEW DECISION

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July 25, 2006

Requestor

Respondent

Texas Mutual InsuranceCo.
ATTN: Rick Ball
Fax#: (512) 224-7094

RE: Claim #:
Injured Worker:
MDR Tracking #: M2-06-1401-01
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 Anesthesiology, 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 ___ when he was unloading barrels in a truck and was pinned between a truck and the dock and suffered a crush injury to the right knee. He underwent surgery which healed and then developed a complex regional pain syndrome from that.

Requested Service(s)

Lumbar (epidural steroid injection) ESI with local anesthetic x series of 5 with P.T. 3 x a week immediately following

Decision

It is determined that the lumbar ESI with local anesthetic x series of 5 with P.T. 3 x a week immediately following are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has a well documented history of intractable pain following a crush injury with femoral condylar fractures of the right lower extremity, with subsequent development of complex regional pain syndrome (RSD). He has undergone a series of lumbar sympathetic blocks with no sustained pain relief, a trial of implantation of a spinal cord stimulator system which required surgical explantation due to lead migration, and is presently being treated with analgesics and a home exercise program. There is no clinical indication for a lumbar epidural steroid injection in this setting, or for a series of 5 ESI's with physical therapy. Specifically, there is no indication for epidural steroids, and the patient has already demonstrated a sympathetically independent mechanism of pain based on the failure of lumbar sympathetic blocks. Therefore the requested lumbar ESI x 5 with PT are not medically necessary

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.

M2-06-1401-01
Page 3

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: 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 25th day of July 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-06-1401-01

Information Submitted by Requestor:

- Outpatient evaluation by Dr. Fillmore
- Letter from Medical Case Manager
- Rx for change of orthopedic surgeon
- Rx from Dr. Fillmore
- Operative Reports
- History and Physical
- Report of CT scan of lower extremity
- Report of x-rays of right knee
- Report of venous duplex of right lower extremity
- Office notes Dr. Miller
- Physical examination by Dr. Hoover
- Office notes Dr. Lai
- Initial Evaluation from Dr. Benhamou
- Physical Therapy progress notes and therapy updates

Information Submitted by Respondent:

- Carrier's Statement
- History and Physical
- Operative Report
- Outpatient Evaluation
- Letter of Determination