

NOTICE OF INDEPENDENT REVIEW DECISION

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July 31, 2006

Requestor

Valley Total Healthcare Systems
ATTN: Nick Kempisty
510 West Drive
Dallas, TX 75208

Respondent

TPCIGA for Petrosurance Casualty
ATTN: David Gelbach
9120 Burnet Rd.
Austin, TX 78758

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-06-1646-01
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, 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 carrying a pipe with a co-worker and the co-worker let the pipe go causing the patient to injure his lumbar spine. The patient has been treated with physical therapy as well as a work hardening program.

Requested Service(s)

Chronic pain management program times ten (10) sessions

Decision

It is determined that the chronic pain management program times ten (10) sessions is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient meets accepted criteria for enrollment into a behavioral chronic pain program. He has failed multiple primary and secondary levels of care over several years and has significantly indicative scores on his BDI and GAF testings of poor function and depression. Based on the patient's treatment course and his current status, an initial 10 day course of the chronic pain program outlined by the requesting physician is justified.

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
Attachment

cc: _____, Injured Worker
Program Administrator, Medical Review Division, DWC

<p>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 July 2006.</p> <p>Signature of IRO Employee:</p> <p>Printed Name of IRO Employee:</p>

Attachment

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-06-1646-01

Information Submitted by Requestor:

- Decision letter from Texas Property & casualty Insurance
- Table of Disputed Services
- Letter of adverse determination
- Request for Appeal
- Letters from Desirae Valadez
- Evaluation from Valley Total Healthcare Systems
- FCE Summary and Recommendations
- Oswestry Low Back Disability Questionnaire
- Letters of medical necessity from Shorman

Information Submitted by Respondent:

None