


INDEPENDENT REVIEW INCORPORATED

August 1, 2006

Re: MDR #: M2 06 1700 01 Injured Employee: ___
DWC #: DOI: ___
IRO Cert. #: 5055 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: Liberty Mutual

REQUESTOR: Texas Health

TREATING DOCTOR: John Botefuhr, DC

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in anesthesiology with special qualifications in pain management and is currently listed on the DWC Approved Doctor List.

**P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)**

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. 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.

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 August 1, 2006.

Sincerely,

A stylized handwritten signature consisting of the lowercase letters 'j' and 'c' in a bold, black font. The 'j' has a dot above it, and the 'c' is a simple, rounded shape.

Jeff Cunningham, DC
Office Manager

**REVIEWER'S REPORT
M2 06 1700 01**

Information Provided for Review:

1. Notification of IRO assignment
2. Information provided by insurance carrier
3. Correspondence from providers
4. Texas health records dated 04/28/06 through 06/09/06
5. Office visits and notes dated 03/07/06 through 06/29/06
6. Surgical reports
7. Radiology reports

Clinical History:

The patient is a 28-year-old male who suffered an apparent work-related injury to his right elbow, knee, and ankle on _____. The patient was managed conservatively initially with analgesics and physical therapy and finally knee surgery on 05/23/06.

Disputed Services:

Psychological testing and biofeedback.

Decision:

I AGREE WITH THE ADVERSE DETERMINATION OF THE INSURANCE CARRIER ON THIS CASE.

Rationale:

The previous reviewers are correct. There is no evidence in the literature for the use of biofeedback as the sole modality in the treatment of this category of injury. The American College of Occupational and Environmental Medicine Guidelines, Chapter 13, is a useful guide in this case.

Of significance, the requirements to finding a chronic pain syndrome are not necessarily met in this case. Generally the patient should have not definable physical cause of the pain, or the pain is disproportionate to that cause. Furthermore, conventional treatments

for acute injuries should either be non-applicable or have failed. The date of the request for the disputed service is 05/22/06. On 05/23/06 the patient underwent an arthroscopic chondroplasty of the knee by Dr. Wey. On 06/28/06 Dr. Wey commented in his office notes that that patient believed the knee was “much better.” His examination revealed no tenderness, hypersensitivity, or hyposensitivity, and there was flexion to 150 degrees. He wrote as a prescription, “May resume regular duty.” In summary, the patient suffered an acute injury that was resolved by conventional treatment.

Guidelines/Literature Utilized:

See above for The American College for Occupational and Environmental Medicine Guidelines and conventional clinical treatment.