

NOTICE OF INDEPENDENT REVIEW DECISION

November 14, 2006

Bridgepoint I, Suite 300
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Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

Requestor

Smith County Healthcare Systems
ATTN: Nick Kempisty
510 W. Davis Street
Dallas, TX 75208

Respondent

Insurance Co. of the State of PA
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
504 Lavaca, Ste 100
Austin, TX 78701

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-07-0136-01
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 when she was thrown from the machine in which she stands to tug heavy units. She landed on the concrete floor which resulted in immediate pain to her lower back and knees. She was treated with medications, physical therapy and pain management.

Requested Service(s)

Individual counseling aftercare x 4 sessions

Decision

It is determined that the Individual counseling aftercare x 4 sessions is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The proposed treatment is determined to be not medically necessary because the previously attempted chronic pain management program (240 hours) had within it the self-help strategies, coping mechanisms and psychological sessions that are inherent in and central to the proposed individual counseling sessions. Much of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any meaningful way from repeating unsuccessful treatment, the proposed treatment is not supported and medically unnecessary.

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

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 14th day of November 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0136-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Letters from attorneys
- Table of disputed services
- Decision letters
- Mental and behavioral Health Consultation & Progress Notes
- Multidisciplinary Pain Management Program Psychological Progress Notes
- Relaxation and Breathing Therapy Session Notes
- Smith County Weekly Summary Notes
- Designated Doctor Report by Dr. Ochoa
- Report of EMG
- Initial Complex Evaluation by Dr. Foox
- Independent Medical Evaluation by Dr. Corley
- Report of x-ray of the right knee
- Report of x-ray of the left knee
- Report of x-ray of the thoracic spine
- Report of x-ray of the lumbar spine
- Report of x-ray of the cervical spine
- Evaluation by George Esterly, M.S., LPC
- Weekly Summary Physical
- Weekly Summary Medical
- Report of MRI of the cervical spine
- PEER Reviewer Final Report
- Neuro History and Physical by Dr. Giri
- History and Physical by Dr. Brylowski
- PEER Review Decision
- Chiropractic Evaluation by Dr. Martin
- Request for preauthorization of additional sessions of pain management.