

NOTICE OF INDEPENDENT REVIEW DECISION

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December 19, 2006

Requestor

Injury 1 Treatment Center
ATTN: James Odom
5445 La Sierra Dr., #204
Dallas, TX 75231

Respondent

TAC WC Self Insurance Fund
c/o Parker & Associates
ATTN: William Weldon
7600 Chevy Chase Dr., Ste 350
Austin, TX 78752

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-07-0270-01
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 Family Practice, by the American Board of Family Practice, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1980, 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 clearing brush with a long handled blade when he struck a solid object. This was a blunt force injury to the left elbow consistent with an ulnar nerve palsy and cubital tunnel syndrome. The patient has been treated with various modalities including medications, injections, and physical therapy. In spite of this, the patient continued to have pain and associated psychological problems including adjustment disorder.

Requested Service(s)

90901- Biofeedback Therapy one weekly for 4 weeks with three modalities (EMG, PNG, and TEMP)

Decision

It is determined that the proposed 90901- Biofeedback Therapy one weekly for 4 weeks with three modalities (EMG, PNG, and TEMP) is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The issue is the medical necessity of biofeedback modalities in the treatment of this patient's condition. Numerous studies have been done to evaluate this including a 1996 panel by the WIH. This panel, the "Integration of Behavior and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia" panel found that while there was moderate benefit to biofeedback, the data was insufficient to conclude one technique was more effective than the other. The 1996 TEC Assessment concluded that evidence was "insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain". The American Pain Society Publications, APS Bulletin, Vol. 14, No.4, 2004 "Biofeedback as an Adjunctive Treatment Modality in Pain Management" Robert J. Gatchel PhD ABPP, suggests that there may be some benefit to biofeedback in the treatment of upper extremity pain, however, it is no better than other less expensive and less instrument oriented treatments.

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.

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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 19th day of December 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0270-01

Information Submitted by Requestor:

None

Information Submitted by Respondent:

- Letter from Attorneys
- Scott and White office notes
- HealthSouth progress notes
- HealthSouth plan of care
- HealthSouth daily notes
- Impairment Rating by Dr. Bishop
- EMG/Nerve Conduction Study
- History and Physical by Dr. Crockett
- Office note from Dr. Crockett
- Results of MRI of the left elbow
- PT Initial Evaluation
- Behavioral Medicine Consultation
- Reviewer opinion form by Dr. Schmudt
- Behavioral medicine testing results
- Individual psychotherapy notes
- Psychophysiological Profile Assessment
- Reconsideration for behavioral health treatment preauthorization request.
- Disability determination by Dr. Bernstein