

NOTICE OF INDEPENDENT REVIEW DECISION

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December 4, 2006

Requestor

Valley Total Health Care Systems  
ATTN: Nick Kempisty  
510 W. Davis Street  
Dallas, TX 75208

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 #: M2-07-0372-01  
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 Orthopedic Surgery, by the American Board of Orthopaedic Surgery, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1969, 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 standing on a board over a septic tank when the board broke causing him to fall into the tank. This resulted in injury to his left hip, left thigh, left elbow, back and knees. The patient has been treated with chiropractic care, physical therapy, chronic pain management program, and epidural steroid injections.

Requested Service(s)

Chronic behavioral management program times (10) sessions

Decision

It is determined that the chronic behavioral management program times (10) sessions is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that this patient has developed a chronic pain behavior syndrome. The pain management program that was authorized in 2004 was completed unsuccessfully. There is nothing presented in the medical record documentation to suggest that a repeat program would have any different end result. This program has been tried and failed. A repeat pain management program has little likelihood of success especially when so much time has passed between injury and the current request. After more than 2 years, pain management programs have little chance of success.

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 4th day of December 2006.

Signature of IRO Employee:  
Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:** \_\_\_\_

**Tracking #:** M2-07-0372-01

**Information Submitted by Requestor:**

None

**Information Submitted by Respondent:**

- Report of x-ray of chest
- Report of CT of the lumbar spine
- Report of lumbar discogram
- Notes of treatment plan from Valley Center for Pain and Stress Management
- Chiropractic treatment notes
- Pre-authorization requests
- Letter from Forte
- Evaluation by Valley Total Healthcare Systems
- Office visit notes from Dr. Chowdhury
- Office notes from Dr. Tijmes
- Report of Consultation by Dr. Obermiller