

NOTICE OF INDEPENDENT REVIEW DECISION

Bridgepoint I, Suite 300
5918 West Courtyard Drive • Austin, TX 78730-5036
Phone 512-329-6610 • Fax 512-327-7159 • www.tmf.org

February 12, 2007

Requestor

Alta Vista Healthcare
ATTN: James Odom
5445 La Sierra Dr., #204
Dallas, TX 75231

Respondent

Texas Mutual Insurance Company
ATTN: Richard Ball
Fax#: (512) 224-7094

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-07-0585-01
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 Physical Medicine and Rehabilitation, by the American Board of Physical Medicine and Rehabilitation, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1979, 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 fell from a ladder. He sustained a fracture of the left distal radius that required external fixation and a bone graft. A second procedure was necessary for the nonunion of the ulnar styloid. He subsequently received surgery for an injury to the shoulder. He also had an AC joint arthritis and rotator cuff impingement and ulnar cubital tunnel syndrome. He had surgery for these problems as well. He had ongoing chronic pain in the upper extremity.

Requested Service(s)

Individual psychotherapy (6 sessions) and biofeedback (6 visits)

Decision

It is determined that the individual psychotherapy (6 sessions) is medically necessary to treat this patient's condition. However, the Biofeedback (6 visits) is not medically necessary.

Rationale/Basis for Decision

There is not a clear purpose for the biofeedback at this time. Biofeedback for pain was reviewed in the American Pain Society Bulletin. Volume 4, number 4, 2004. Dr. Gatchel noted it was of some value for some people when "biofeedback training does provide subjects with information that enable them to control voluntarily some aspect of the physiology that may contribute to the pain experience...biofeedback is most beneficial for patients when used as one adjunctive component of an interdisciplinary pain management program....Biofeedback in combination with CBT (cognitive behavioral therapy) increases the patient's sense of self-efficacy by ...gain(ing) control over certain physiological responses." He further noted that there were few "well-controlled studies...that exist (and these) suggest that biofeedback can aid in treatment effectiveness." He did not elaborate on the cause of the pain in these studies other than say, "e.g., carpal tunnel syndrome." The requesting parties cited its benefit in the treatment of shoulder instability. The records did not establish, however, that the patient suffers from instability. Therefore, the biofeedback is not medically indicated.

The individual psychotherapy is medically necessary due to chronic pain. This patient's lack of improvement was apparently due to his pain. The treatment guidelines for pain medicine would deem the proposed psychotherapy treatments appropriate as the medical record documentation indicates that the patient had been improving.

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.

M2-07-0585-01
Page 3

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 12th day of February 2007.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0585-01

Information Submitted by Requestor:

- Patient Face Sheet
- Table of Disputed Services
- Behavioral Health Treatment Preauthorization Request
- Decision Letters
- Reconsideration: Behavioral Health Treatment Preauthorization Request
- Behavioral Medicine Re-Evaluation
- Report of MR arthrography left shoulder
- Reports of MRIs of the cervical spine
- Radiographic Biomechanical Report
- Follow up consultation notes from Dr. Dutra
- Dynamic Fluoroscopic Study of the Cervical Spine
- Report of lumbar epidural steroid injection
- Report of CT of the left wrist
- Operative Report
- Neuro-surgical Evaluation
- Report of Nerve Conduction Velocity Test

Information Submitted by Respondent:

- Carrier's statement with respect to this dispute
- Designated Doctor Evaluation by Dr. Robert Jones
- Records review by Dr. Robert Jones
- Follow up evaluations by Dr. Dutra
- Decision Letter
- Physical Therapy Evaluation
- Functional Abilities Evaluation