

NOTICE OF INDEPENDENT REVIEW DECISION

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October 24, 2005

Amended Letter: November 11, 2005

Requestor

Respondent

Ace American Insurance Company
ATTN: Javier Gonzalez
Fax#: (512) 394-1412

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-05-2262-01
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 40 year old female fell at work on ___ and suffered a radial head fracture of the right arm. The patient underwent a radial head excision on 08/09/2004 and persistent wrist pain led to wrist debridement and ligament repair on 01/28/2005. The treating physician is now requesting a radial head replacement.

Requested Service(s)

Right elbow arthroscopy with radial head implant

Decision

It is determined that the right elbow arthroscopy with radial head implant is not medically appropriate to treat this patient's condition.

Rationale/Basis for Decision

Based on review of the medical record documentation including the required medical evaluation, and applicable literature, it would not be appropriate to recommend radial head implant surgery at this time. Series reports do not include a significant number of patients, however, only 30% of patients undergoing radial head implant surgery report improvements in symptoms. It is not reasonable to recommend such surgery when patient's reporting no improvement or worsening of symptoms are greater than 2:1.

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: Program Administrator, Medical Review Division, DWC

In accordance with Commission 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 24th day of October 2005.

Signature of IRO Employee:

Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-05-2262-01

Information Submitted by Requestor:

- Pre-authorization
- MD office notes
- Discharge evaluation PT notes
- Progress reports
- Consultations
- Operative note
- Radiology reports
- Medial evaluation

Information Submitted by Respondent and Treating Doctor:

- Office notes
- Pre-authorization
- Progress reports
- MRI
- Re-evaluation and Rx plan
- Orthopedic consultation
- Required medial evaluation
- Operative report
- History and Physical
- Discharge summary
- Radiology reports
- Lab reports
- PT reports