

NOTICE OF INDEPENDENT REVIEW DECISION

March 28, 2006

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

Requestor

Texas Health  
ATTN: James Odom  
5445 La Sierra Dr., #204  
Dallas, TX 75231

Respondent

Service Lloyds Insurance Co.  
ATTN: Robert Josey  
P.O. Box 162443  
Austin, TX 78716

RE: Claim #:  
Injured Worker:  
MDR Tracking #: M2-06-0852-01  
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 on \_\_\_\_ when a piece of scaffolding came down and "pinched" his right hand between the two pieces of scaffolding. The records indicate that the injured worker pulled his right hand from between the two pieces of scaffolding and fell backwards. As he fell, he stated that he struck his right hand against a wooden door that was lying against a wall.

Requested Service(s)

Psychological testing (3hrs) and Biofeedback PPA X4 modalities

Decision

It is determined that the psychological testing (3hrs) and Biofeedback PPA X4 modalities are not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that the patient received appropriate treatment for the bruise/contusion injury suffered to his right hand. The medical record documentation does not specifically associate his hand injury with any type of psychological problem that would require the requested testing. Therefore, the requested services are not medically necessary for the treatment of this patient's condition.

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 28th day of March 2006.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

**Patient Name:**

**Tracking #: M2-06-0852-01**

**Information Submitted by Requestor:**

- **Table of disputed services**
- **Behavioral Health Testing Preauthorization Request**
- **Determination Notice**
- **Reconsideration: Behavioral Health Testing Preauthorization Request**
- **Requestor's Position Regarding Preauthorization**
- **Letter from attorney**
- **Initial Behavioral Medicine Consultation**
- **Daily Notes Reports**
- **X-ray report of right hand**
- **Chiropractic Initial Evaluation-Mechanism of injury and Causation**
- **Functional Capacity Testing Report**

**Information Submitted by Respondent:**

**None**