

December 5, 2006

VIA FACSIMILE  
Positive Health Management  
Attention: April Johnson

VIA FACSIMILE  
Texas Mutual Insurance Company  
Attention: Richard Ball

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-07-0264-01**  
**DWC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: Positive Health Management**  
**Respondent: Texas Mutual Insurance Company**  
**MAXIMUS Case #: TW06-0161**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. The TDI, Division of Workers Compensation (DWC) has assigned this case to MAXIMUS in accordance with Rule §133.308, which allows for a dispute resolution by an IRO.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician who is board certified in psychiatry on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the approved doctor list (ADL) of DWC or has been approved as an exception to the ADL requirement. A certification was signed that the reviewing provider has no known conflicts of interest between that provider and 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, was signed. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns an adult male who sustained a work related injury on \_\_\_\_\_. The case file records indicate that while lifting a 100 pound object, he injured his wrists. Diagnoses have included bilateral carpal tunnel syndrome, and psychosocial issues. Evaluation and treatment for this injury has included injections, splinting, physical therapy and ultrasound therapy.

## Requested Services

Preauthorization for 20 days of pain management.

## Documents and/or information used by the reviewer to reach a decision:

### *Documents Submitted by Requestor:*

1. Positive Health Management Records and Correspondence – 9/5/05-9/25/06
2. Determination Notices – 9/11/06, 9/20/06
3. Correct Care Clinic Records – 9/5/06

### *Documents Submitted by Respondent:*

1. Carrier's Statement – 11/15/06
2. Prestige Imaging Records – 1/24/06
3. Independent Medical Evaluation – 5/1/06
4. Designated Doctor Evaluation – 7/24/06
5. Center for Fracture Treatment and Orthopedic Surgery Records – 7/27/06
6. Determination Notices – 9/11/06, 9/20/06, 10/30/06
7. Michael E. Muncy, DO Records – 10/4/06

## Decision

The Carrier's denial of authorization for the requested services is upheld.

## Standard of Review

This MAXIMUS determination is based upon generally accepted standard and medical literature regarding the condition and services/supplies in the appeal.

## Rationale/Basis for Decision

The MAXIMUS physician consultant indicated that the member's provider reported that the member has not responded to conservative management, however review of the records indicate that treatment recommendations for physical therapy do not appear to have been implemented. The MAXIMUS physician consultant also indicated that the provider contends that the patient is not a candidate for surgery but again it appears from the records that the patient saw Dr. Muncy on 10/4/06 and surgery was recommended. The MAXIMUS physician consultant noted that the provider contends the patient has a history of opiate dependency, however review of the records indicate that the patient has not been on opiates and was reluctant to take them. The MAXIMUS physician consultant explained there is no indication of a substance abuse diagnosis in the chart. The MAXIMUS physician consultant indicated that while he was Lexapro, there is no indication of the length of the trial or degree of compliance. The MAXIMUS physician consultant also indicated there was no evidence that outpatient psychotherapy has been tried or that alternatives have been exhausted. The MAXIMUS physician consultant explained that in 2000, KA Karjalainen studied the effects of biopsychosocial rehabilitation programs in patients with repetitive upper limb injuries and found little evidence that these were effective. (Karjalainen KA, et al. Biopsychosocial rehabilitation for repetitive-strain injuries among working-age adults. Scand J Work Environ Health. 2000

Oct;26(5):373-81.) The MAXIMUS physician consultant noted that the data reviewed does not reflect medical necessity for the requested services.

Therefore, the MAXIMUS physician consultant concluded that the preauthorization request for 20 days of pain management is not medically necessary for treatment of the patient's condition.

**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.

Sincerely,  
**MAXIMUS**

Lisa Gebbie, MS, RN  
State Appeals Department

cc: Division of Workers Compensation

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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 5th day of December 2006.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department