

NOTICE OF INDEPENDENT REVIEW DECISION

January 31, 2007

Bridgepoint I, Suite 300
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Requestor

Healthtrust
ATTM: Courtney
P.O. Box 890008
Houston, TX 77289

Respondent

Atlantic Mutual Insurance
c/o Flahive, Ogden & Latson
ATTN: Katie Foster
504 Lavaca, Ste 1000
Austin, TX 78701

RE: Claim #: _____
Injured Worker: _____
MDR Tracking #: M2-07-0596-01
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 she hit her hand on the bottom of a shelf and some items were about to fall on top of the shelf. Evaluations, diagnostic testing, medication, injections, and an aggressive therapy program were performed. She underwent surgery on 02/28/05. Continuation of therapy was recommended. She was seen by a designated doctor on 06/07/05 where she was placed at MMI with a 2% impairment rating.

Requested Service(s)

Chronic pain management – 30 sessions (5 times a week for 6 weeks)

Decision

It is determined that the chronic pain management – 30 sessions (5 times a week for 6 weeks) is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation indicates that this patient has had a multidiscipline approach to the treatment of her injury. Since her injury, she has received treatment from occupational therapists, physicians, chiropractors, surgeons, and psychiatrists. Her injury is approximately 2 years and 9 months old. She has completed an intense treatment program including surgical intervention and rehabilitation. She has not had a significant loss of ability to function independently resulting from the chronic pain. National treatment guidelines including Official Disability Guidelines do not allow for multidisciplinary chronic pain management program without meeting specific entry criteria. The patient does not meet the specific criteria as outlined in the guidelines.

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 31st day of January 2007.

Signature of IRO Employee:
Printed Name of IRO Employee:

Information Submitted to TMF for Review

Patient Name: ____

Tracking #: M2-07-0596-01

Information Submitted by Requestor:

- Request for Medical Dispute Resolution
- Request for Reconsideration
- Request for Services
- Treatment Plan
- Office notes from Dr. Refaeian
- Designated Doctor Evaluation by Dr. Kauffmann
- Office notes from Dr. Tsourmas
- Report of MRI of the right hand
- Chiropractic Office Notes
- Office notes from Dr. Bell
- Occupational therapy notes
- Letter of Medical Necessity from Dr. Gonzalez
- Psychological Evaluation

Information Submitted by Respondent:

- Letters from Attorneys
- Letters of determination