

NOTICE OF INDEPENDENT REVIEW DECISION

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February 21, 2007

Requestor

Positive Health Management  
ATTN: Paris  
2301 Forest Ln., #400  
Garland, TX 75042

Respondent

Ace American Ins. c/o ESIS  
ATTN: Beverly Weygandt  
P.O. Box 31143  
Tampa, FL 33631-3143

RE: Claim #: \_\_\_\_\_  
Injured Worker: \_\_\_\_\_  
MDR Tracking #: M2-07-0766-01  
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 Anesthesiology, by the American Board of Anesthesiology, Inc., licensed by the Texas State Board of Medical Examiners (TSBME) in 1989, 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 she developed a repetitive injury to the right thumb. The patient has been treated with physical therapy, rest, splinting, medication and electrical stimulation.

Requested Service(s)

20-day pain management program

Decision

It is determined that the 20-day pain management program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based on the medical record documentation, this patient's work-up has been negative, including imaging studies, serial electromyography and nerve conduction studies. When the patient was evaluated with a physical performance test, she exhibited sub-maximal effort on grip strength evaluation. At this point, 15 months after the reported injury, the patient has shown no improvement. Therefore, with the minimal pathology and the failure of all previous treatment, there is no indication that the patient would improve with the proposed pain management program.

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 21st day of February 2007.

Signature of IRO Employee:

Printed Name of IRO Employee:

**Information Submitted to TMF for Review**

Patient Name: \_\_\_\_

Tracking #: M2-07-0766-01

**Information Submitted by Requestor:**

- Decision Letter
- Physician Orders from the El Paso Orthopaedic Surgery Group
- Letter from Dr. Viesca
- Office notes from Dr. Viesca
- History and Physical by Dr. Mrochck
- Response from Positive Health Management to request denial
- History and Physical with psychological examination by Positive Health Management
- Positive Health Management, Inc,: Program Description
- Intake Assessment and Report by Positive Health Management
- Overview of the Psychophysiological Assessment
- Physical Performance Evaluation Summary Report – Request for Initiation of Pain Management Program – 20 days
- Initial Examination by Dr. Mallerich
- Individualized Treatment Plan from Positive Health Management

**Information Submitted by Respondent:**

- History and Physical by Dr. Refaeian
- Office notes by Dr. Refaeian
- Electrodiagnostic Medicine Laboratory Report
- Functional Capacity Evaluation
- Office notes from Dr. Klein
- Designated Doctor Evaluation by Dr. Miller
- Impairment Rating Report
- Office notes by Dr. Viesca
- Drug screening report dated 10/11/06
- History and Physical with psychological examination by Positive Health Management
- Report of Physical Performance Test
- Letter of determination