

## NOTICE OF INDEPENDENT REVIEW DECISION

May 13, 2002

Requestor

Respondent

RE: Injured Worker:

MDR Tracking #: M2-02-0566-01

IRO Certificate #: 4326

\_\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_\_ 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 \_\_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The \_\_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_\_ for independent review. 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 male was injured at work on \_\_\_\_ when he fell from an awning and landed face down. The patient underwent a closed reduction and casting of his right hand. Following removal of the cast, he continued to have pain in his wrist. The patient complains of increased wrist pain with movement of his wrist or digits with a burning sensation. The patient current diagnosis is chronic pain syndrome. Conservative treatments have included rest, physical therapy, injections, pain medications, ice and heat, and electrical stimulation.

### Requested Service(s)

5 week (30 session) pain management program

### Decision

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

Rationale/Basis for Decision

A pain management program is not indicated for this patient. The patient has no emotional stress that would impede his progress or his response to treatment. Additionally, since the patient is having pain upon motion, consideration should be given for him to have the most recent x-rays presented to a hand surgeon for advise or further treatment including wrist fusion.

This decision by the IRO is deemed to be a TWCC decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code '148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

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 \_\_\_\_\_ day of \_\_\_\_\_ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: