

August 27, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0728-01
IRO Certificate No.: I RO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedic Surgery.

The physician reviewer AGREES with the determination made by the insurance carrier in this case. The reviewer has determined that arthrotomy of the wrist with debridement is not medically necessary in this case.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

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

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

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 27TH day of August, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0728-01, in the area of Orthopedics. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical records.
2. Physical therapy notes.
3. Operative reports.
4. X-ray reports.

B. BRIEF CLINICAL HISTORY:

This is a 28-year-old hockey player who was involved in an accident on _____. At that time, he had wrist pain and was seen the following day. An MRI was done which was negative. He eventually underwent injection and was treated conservatively. The pain did not resolve, and eventually diagnoses of triangular fibrocartilage complex tear along with scapholunate tear and scapholunate arthritis were made. The patient underwent an attempt at scapholunate fusion but this was unsuccessful, and a second attempt at fusion was unsuccessful.

By reports, the patient continues to have pain in his wrist, and he has been seen by several physicians. It has been suggested that the patient either undergo a wrist fusion or an ulnar procedure, either a styloidectomy or shortening along with debridement of the triangular fibrocartilage complex tear or consider a wrist fusion.

C. DISPUTED SERVICES:

Arthrotomy of the wrist and an ulnar procedure, either styloidectomy or shortening.

D. DECISION:

I DO NOT THINK THIS IS ABSOLUTELY MEDICALLY NECESSARY TO BE DONE.

E. RATIONALE OR BASIS FOR DECISION:

I do not think there is an ideal procedure for this individual with the difficult situation that he has.

However, I would add the following comments. The clinical evaluation is important, and if the patient were having severe pain, with inability to function, I think an arthrotomy with debridement of the triangular fibrocartilage complex and an ulnar shortening procedure would probably be the most reasonable approach. A wrist fusion in this individual is a major event and probably would not be satisfactory for his lifestyle. These types of decisions have to be made on the clinical basis of evaluating the patient for a long period of time and understanding how much pain he is having and what his desires of function are.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 19 August 2002