

NOTICE OF INDEPENDENT REVIEW DECISION

October 22, 2002

RE: MDR Tracking #: M2-02-1189-01
IRO Certificate #: IRO 4326

The ___ 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 30 year old male sustained a work related injury when he was lifting a dishwasher and injured his right wrist. The MRI of the right wrist on 04/04/02 revealed no evidence of a tear of the triangular fibrocartilage ligament and no evidence of any intracarpal ligament disruption. A work hardening program has been recommended.

Requested Service(s)

Six-week work hardening program.

Decision

It has been determined that a six-week work hardening program is not medically necessary.

Rationale/Basis for Decision

The 04/04/02 MRI of the right wrist revealed no evidence of fractures or stress reactive changes in the carpal bones. The triangular fibrocartilage was intact and the axial images of the wrist demonstrated a normal median nerve. The extensor tendons were intact and some fluid encircling the extensor carpi radialis longus tendon was noted at the distal third of the forearm that represented possible tenosynovitis. In addition, the radiocarpal joint was intact. A report dated 06/17/02 indicated that the patient was treated following the injury by an orthopedic surgeon. A short fiberglass cast was applied for three weeks and the patient underwent physical therapy. The report also indicated that the mechanism of injury was not consistent with carpal tunnel syndrome; the patient was most likely at maximum medical improvement as of 04/04/02 with 0% impairment; and no further testing or treatment was likely indicated for the patient's wrist injury. The medical record documentation contains no data pertaining to functional deficits preventing a return to work that would necessitate the use of a six-week work hardening program. Therefore, the six-week work hardening program is not medically necessary.

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.

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 10 (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

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 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 should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission 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 22 nd day of October 2002.
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