

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 6, 2002

Re: IRO Case # M2-03-0144

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation. He or she has signed a certification statement attesting 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 referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient is a 48-year-old male who was injured ___ when he fell from a tractor about six feet high, landing on his wrist and the left side of his body. X-rays of the wrist were significant for an acute comminuted fracture of the distal radius extending into the radiocarpal joint. A CT scan of the left wrist showed a distal radial ulnar styloid fracture. The patient underwent closed reduction and percutaneous pinning with external fixator surgery on 3/19/02. The hardware and external fixator were removed 5/20/02.. Post operatively the patient was treated with physical therapy for the hand and wrist. A 7/30/02 FCE showed the patient to be at a light-medium to medium physical demand level. His job as a heavy equipment operator reportedly requires a medium physical demand level. He was found to not meet his previous work level.

Requested Service

Work hardening program 3 weeks

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

While the FCE points out functional deficits in strength and endurance, there is no objective evidence that a multi disciplinary approach to therapy is needed. There is no evidence of a need for psychological or vocational counseling. The patient would benefit from more therapy, but a single disciplinary approach would be more appropriate in this case.

This medical necessity decision by an Independent Review Organization 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 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** (ten) days of your receipt of this decision (28 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 a hearing should be sent to:

Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this 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,