

April 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0230-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___- external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 31 year-old male who sustained a work related injury on ___. The patient reported that while at work he was removing asbestos and paper with a sharp knife. The patient accidentally cut himself over the right wrist. The patient was initially evaluated at an emergency room where he underwent X-Rays and sutures were placed. The patient was treated with pain medications and released. The patient continued to complain of pain and was evaluated by pain management where he underwent an EMG. The diagnoses for this patient include laceration of the right wrist and right wrist internal derangement syndrome.

Requested Services

Outpatient Stellate Ganglion nerve block.

Decision

The Carrier's denial of authorization and coverage for the requested services is upheld

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient cut the volar aspect of his right wrist with a knife. The ___ physician reviewer explained that since the injury the patient has complained of hand weakness, continued pain and numbness in the area of the thenar eminece. The ___ physician reviewer noted that in 10/02 the patient has undergone evaluation by a hand specialist. The ___ physician reviewer also noted that the hand specialist felt that there was no evidence of nerve or muscle tendon unit deficit. The ___ physician reviewer explained that the patient has been under the care of pain management specialist since 8/02. The ___ physician reviewer noted that the patient has been treated with Neurontin, Celebrex and a topical gel composed of Clonidine, Garbapentin, Ketamine and Lidocaine. However, the ___ physician reviewer also noted that despite the pain management treatment, the patient continues to complain of pain. The ___ physician reviewer explained that the pain management specialist has recommended a Stellate Ganglion block as a diagnostic procedure in an attempt to confirm or rule out reflex sympathetic dystrophy as the source of this patient's pain. The ___ physician reviewer also explained that this patient has undergone evaluation by a hand specialist and a neurologist. The ___ physician reviewer noted that both the neurologist and hand specialist indicated that there was no evidence of reflex sympathetic dystrophy or carpel tunnel syndrome as a result of the injury. The ___ physician reviewer indicated that this patient's neurology evaluation exam was normal except for numbness in the inner eminence. The ___ physician reviewer also indicated that the diagnosis for this patient's numbness in the inner eminence is felt to be neuropathy of the right cutaneous nerve of the right hand as a consequence of a laceration of the right wrist. The ___ physician reviewer explained that the medical documentation does not support the medical necessity of the requested Stellate Ganglion nerve block as conservative treatment is available his condition. Therefore, the ___ physician consultant has concluded that the Stellate Ganglion nerve block is not medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 23rd day of April 2003.