

February 19, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0519-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopaedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ is a 66-year-old gentleman who was seriously injured in a tractor accident when he caught his right upper extremity in the spinning blades of a tractor. The injury resulted in a traumatic below elbow amputation of his forearm and a dislocation of his right shoulder. Both injuries were on the right upper extremity. The patient was taken to the local emergency room where he was evaluated medically and was prepared for surgical treatment of his traumatic amputation. He had a closed reduction of the dislocated shoulder and he underwent debridement and closure of the traumatic amputation by \_\_\_. The patient had a fairly uncomplicated postoperative recovery period. He has other health problems including diabetes and coronary artery disease, but he did not develop any infection following the surgical debridement and closure of the traumatic amputation. \_\_\_ had considerable limitation of motion in his shoulder and it demonstrated a rotator cuff tear and considerable evidence of subacromial impingement syndrome. Surgical treatment for his shoulder was discussed, but he patient and family were not interested in obtaining any surgical treatment for the shoulder. He had limitation of motion in his shoulder and had difficulty moving his shoulder. This delayed his fitting with a prosthesis for his amputation. The treating physician has ordered a Myoflex below elbow prosthesis that was not approved by the insurance carrier.

## REQUESTED SERVICE

The treating physician has ordered a Myoflex below elbow prosthesis for \_\_\_\_

## DECISION

The reviewer disagrees with the prior adverse determination.

## BASIS FOR THE DECISION

Though this gentleman is 66-years-old with considerable limitation of motion and restriction in his right shoulder, it is logical that he should receive a right below-elbow prosthesis. The treating physician has ordered a Myoflex below elbow prosthesis for \_\_\_\_, and the reviewer finds that a prosthesis is medically appropriate and necessary in this case.

\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## 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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 19<sup>th</sup> day of February 2003.**