

August 8, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1518-01

___ 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 occupational medicine and public health. 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 48 year-old male who sustained a work related injury on ___. The patient reported that while at work he was attempting to attach a trailer onto a hitch when he fell causing injury to his right wrist. The diagnosis for this patient is right wrist distal radius comminuted fracture with displacement. The patient underwent a right wrist closed reduction and manipulation, application of distal radius external fixator, and percutaneous pinning with two K-wires on 10/24/02. The patient underwent a right wrist removal of external fixator, and removal of percutaneous pinning on 12/19/02. Post surgically the patient underwent an X-Ray on 3/19/03. The patient has also been treated with conservative measures.

Requested Services

Work conditioning program, daily times 4 weeks.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 48 year-old male who sustained a work related injury to his right wrist on ___. The ___ physician reviewer also noted that the diagnosis for this patient is right wrist distal radius comminuted fracture with displacement. The ___ physician reviewer further noted that the patient underwent a right wrist closed reduction and manipulation, application of distal radius external fixator, and percutaneous pinning with two K-Wires on 10/24/02. The ___ physician reviewer explained that a literature review produced one reference to grip force and its relationship to returning to work. However. The ___ physician reviewer also explained that this reference indicated that greater strength did not predict

success with returning to work (Matheson LN et al. Relationships among lifting ability, grip force, and return to work. Physical Therapy, 2002:82(3): 249-256). The ___ physician reviewer indicated that the patient has the ability to meet most of his job requirements. The ___ physician reviewer explained that the employer has offered the patient accommodated duties. The ___ physician reviewer also explained that if work related activities such as shoveling are problematic, it is recommended that the patient build up slowly to maximal workload for this activity or other limited activities. The ___ physician reviewer also explained that because the patient already meets his job requirements, it is unclear what the end result of a work-conditioning program would be. Therefore, the ___ physician consultant concluded that the requested work conditioning program, daily times 4 weeks, 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 8th day of August 2003.