

November 18, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0302-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in orthopedic surgery. 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 39 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell from a 18-foot scaffold, landing on his head. The patient sustained a closed head injury, fracture of the base of the skull and a fracture of the left clavicle. An X-Ray of the left shoulder showed a fracture of the medial to outer third of the clavicle and a non-displaced fracture of the super-medial corner of the scapula. A follow up X-Ray on 9/19/03 indicated that there is no evidence of callus formation indicating a healing process 6 weeks post fracture. The diagnosis for this patient is displaced non-union fracture of the left clavicle.

Requested Services

Bone Growth Stimulator.

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 39 year-old male who sustained a work related injury to his left clavicle on ___. The ___ physician reviewer also noted that a X-Ray of the left shoulder showed a fracture of the medial to outer third of the clavicle and a non-displaced fracture of the super-medial corner of the scapula. The ___ physician reviewer further noted that a follow up X-Ray 6 weeks post fracture on 9/19/03 indicated that there was no evidence of callus formation indicating a healing process. However, the ___ physician reviewer

explained that at 6 weeks the absence of callous formation, even with a displaced clavicle fracture, does not constitute a non-union. The ___ physician reviewer also explained that absence of callous formation at the 6 weeks further does not indicate that the clavicle fracture will not heal. Therefore, the ___ physician consultant concluded that the requested bone growth stimulator 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 18th day of November 2003.