

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

March 16, 2004

**Re: IRO Case # M2-04-0789**

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 Orthopedic Surgery, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. 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

This patient is a 34-year-old male who injured his left hand, wrist, elbow, and forearm on \_\_\_\_\_. The patient fell backwards while carrying a scaffold with a co-worker. The patient landed on his back and elbow with his elbow flexed approximately 90 degrees. The scaffold landed on his left wrist, causing immediate pain and swelling. A company doctor performed x-rays, prescribed medications, applied a thumb spica splint, diagnosed a scaphoid fracture, and referred the patient to an orthopedic surgeon. On 10/25/02 the patient underwent closed reduction and percutaneous pinning of his left scaphoid fracture.

The fracture did not heal and went on to a nonunion. The patient subsequently underwent a second surgical procedure on 5/9/03. He underwent bone grafting and internal fixation of the scaphoid nonunion with a limited radial styloidectomy. Functional capacity evaluations after the injury and after the second surgery revealed that the patient is significantly weak and requires work hardening.

Requested Service(s)

Work conditioning program x six weeks

Decision

I disagree with the carrier's decision to deny the requested WHP.

Rationale

The decision to deny work hardening is based on the peer review indicating that the patient suffered a sprain injury to the left wrist. However, the patient suffered a much more debilitating problem. He suffered a fractured scaphoid which went on the nonunion, requiring two surgeries. The FCE reports indicate that the patient demonstrated sincere effort, but was significantly debilitated and weak. A work-conditioning program is indicated to allow this patient to return to the workforce.

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 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) calendar 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 16<sup>th</sup> day of March 2004.