

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-05-7472.M2**

May 20, 2005

VIA FACSIMILE
Arie Salzman, MD
Attn: Arie Salzman

VIA FACSIMILE
Texas Mutual Ins.
Attn: Ron Nesbitt

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination 6/6/05**

**RE: MDR Tracking #: M2-05-1487-01
TWCC #: ____
Injured Employee: ____
Requestor: Arie Salzman, MD
Respondent: Texas Mutual Ins.
MAXIMUS Case #: TW05-0088**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient underwent open reduction and internal fixation of the left distal radius and ulnar fracture with bone allografting on 1/26/05. Post operative physical therapy was reportedly started in late 2/2005.

The patient has continued complaints of stiffness of the finger MP, PIP and DIP joints. The patient has been recommended for manipulation under anesthesia (MUA) of all fingers and thumbs, and all joint of the left hand, for further treatment of her condition.

Requested Services

MUA all Finger and Thumbs, all joints left hand w/1 day inpatient stay.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. Position Statement 5/2/05
2. Progress Notes 2/3/05 - 2/21/05

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her left distal radius and ulnar on _____. The MAXIMUS physician reviewer also noted that the patient underwent open reduction and internal fixation of the left distal radius and ulnar fracture with bone allografting on 1/26/05 followed by postoperative physical therapy begun in 2/2005. The MAXIMUS physician reviewer further noted that the patient has been recommended for manipulation under anesthesia of all fingers and thumbs, and all joint of the left hand, for further treatment of her condition. The MAXIMUS physician reviewer indicated that there are very few indications for simple closed manipulation of TU finger joints because the TU trauma itself results in pain and an inflammatory response. The MAXIMUS physician reviewer explained that several months of therapy are an essential prerequisite to consideration of surgical release of a contracture. The MAXIMUS physician reviewer also explained that there is no literature supporting the requested services for the treatment of this patient's condition. Therefore, the MAXIMUS physician consultant concluded that the requested MUA all Finger and Thumbs, all joints left hand w/1 day inpatient stay 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,
MAXIMUS

Elizabeth McDonald
State Appeals Department

cc: Texas Workers Compensation Commission
Ms. ____

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 6th day of June 2005.

Signature of IRO Employee: _____
External Appeals Department