

August 16, 2005

VIA FACSIMILE  
Mr. Jon Grove  
Downs & Stanford, PC

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-2070-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent: Downs & Stanford, PC**  
**MAXIMUS Case #: TW05-0155**

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 44 year-old female who sustained a work related injury to her left arm on \_\_\_\_\_. She has been diagnosed with left wrist tendonitis, sprain of the elbow and medial epicondylitis. The patient has been treated with medications, an injection, a left carpal tunnel splint, a left ulnar nerve submuscular anterior transposition and partial medial epicondylectomy with medial epicondyle debridement on 5/13/04, and physical therapy. An EMG/NCV performed on 2/12/04 revealed an ulnar nerve entrapment at the elbow and mild entrapment at Guyon's canal. An MRI of the patient's left wrist and elbow performed on 9/15/04 revealed an old distal radial fracture, radiocarpal osteoarthritis, ununited ulnar styloid fracture with a suspected peripheral tear of the TFCC, lunotriquetral ligament disruption with focal effusion, and edema and swelling of the muscles medial to the medial compartment of the left elbow.

## Requested Services

MRI of the upper extremity any joint without dye

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

### *Documents Submitted by Requestor:*

1. Operative report dated 5/13/04
2. Orthopedic surgeon's records from 6/15/04 to 8/20/04

### *Documents Submitted by Respondent:*

1. Cover letter dated 7/27/05
2. Denial letters dated 5/27/05 and 6/17/05
3. Nurse's chronological list of submitted records dated 8/23/04
4. Physician advisor review dated 8/19/04
5. Medical record Review report dated 5/17/05

## 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 44 year-old female who sustained work related injury to her left arm on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that this patient has undergone multiple procedures for treatment of this left arm injury, including ulnar nerve transposition surgery. The MAXIMUS physician reviewer also indicated that an MRI of her left wrist and elbow performed on 9/15/04 revealed arthritic changes and tendonitis. The MAXIMUS physician reviewer explained that there is no evidence that the results of another MRI would change the treatment plan for this patient. The MAXIMUS physician review indicated that she has already undergone elbow surgery and that she has documented arthritis and tendonitis. The MAXIMUS physician reviewer also indicated that conservative measures are indicated for treatment of the patient's left arm pain at this point. The MAXIMUS physician reviewer explained that the results of another MRI are unlikely to change this treatment recommendation or the patient's prognosis at this time. Therefore, the MAXIMUS physician consultant concluded that requested MRI of the upper extremity any joint without dye 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**

Lisa K. Maguire, Esq.  
Project Manager, State Appeals

cc: Texas Workers Compensation Commission

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 16<sup>th</sup> day of August 2005.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department