

September 21, 2005

VIA FACSIMILE:
Zurich American Insurance Company
Attention: Annett Moffett

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2280-01
TWCC #:
Injured Employee:
Requestor:
Respondent: Zurich American Insurance Company
MAXIMUS Case #: TW05-0183

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 56-year old female who sustained a work related injury on _____. The patient reported that she fell while working as a grill cook. She also reported moderate mechanical pain located at the right shoulder, arm, elbow, forearm and wrist after the fall. Diagnoses included right hand arthritis and right carpometacarpal sprain/strain. Evaluation and treatment have included external immobilization, injections, MRI, electromyography/nerve conduction studies and x-rays.

Requested Services

Preauthorization request for right carpometacarpal (CMC) arthroplasty

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

Documents Submitted by Requestor:

1. None submitted.

Documents Submitted by Respondent:

1. Follow-up office note from Marcos V. Masson, MD – 7/13/05
2. Electromyography report – 2/8/05
3. Designated Doctor Evaluation – 6/10/05
4. Statements of Carrier's Determination – 8/24/05, 9/6/05

Decision

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

Rationale/Basis for Decision

MAXIMUS physician consultant indicated that the patient has multiple upper extremity complaints after a fall on ___ while working as a grill cook. MAXIMUS physician consultant noted she has mild carpometacarpal joint arthrosis and an injection of this joint only gave her partial relief. MAXIMUS physician consultant explained that it is not likely that the proposed carpometacarpal arthroplasty will be effective in relieving her pain. MAXIMUS physician consultant noted her presentation is multifactorial with her physical examination also showing multiple muscle groups with 4+/5 weakness. MAXIMUS physician consultant also indicated that mild carpometacarpal joint arthrosis is not an indication for arthroplasty. (Green D. Textbook of Hand Surgery)

Therefore, the MAXIMUS physician consultant concluded that the requested right carpometacarpal (CMC) arthroplasty is not medically necessary for treatment of this patient's condition.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Sincerely,
MAXIMUS

Lisa Gebbie, MS, RN
State Appeals Department

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 21st day of September 2005.

Signature of IRO Employee: _____
External Appeals Department