

June 28, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0513-01
IRO Certificate No.: I RO 5055

Dear:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Orthopedic Surgery.

THE PHYSICIAN REVIEWER AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE. SURGERY FOR LEFT CARPAL TUNNEL RELEASE AND LEFT RADIAL NERVE RELEASE IS NOT MEDICALLY NECESSARY.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** 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
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

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.

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 28TH day of June, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is ___ for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0513-01, in the area of Orthopedic Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of surgery for left carpal tunnel release and left radial nerve release.
2. Correspondence from ___.
3. Correspondence from ___.
4. Report of neurological consultation by ___.
5. Report of nerve conduction velocity and electromyographic studies, dated 7/03/01.
6. Notes and letters from ___ regarding the patient, dated 9/25/01 through notes of 2/05/02.
7. Note from physician advisor.

B. SUMMARY OF EVENTS:

The patient is a 42-year-old female who complains of symptoms of numbness and tingling in both hands, beginning ___. The presented cause was repetitive use syndrome. She had been treated conservatively with splinting, NSAID's, muscle relaxants and physical therapy including ultrasound, mostly from May through September 2001. A wrist brace was prescribed on 9/10/01.

Because of presumed failure of non-surgical treatment, she was referred to ___ who requests pre-authorization for carpal tunnel release of the left hand, and left radial nerve release.

C. DISPUTED SERVICES:

A physician advisor recommends denial, stating there should be more current documentation of the need for surgery, specifically (1) the current status of her symptoms, (2) objective clinical findings, and (3) current diagnostic testing.

D. DECISION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER.
SURGERY IS NOT MEDICALLY NECESSARY IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

1. Although the patient's symptoms have not been "cured" over a period of 16 months of appropriate non-surgical modalities (splinting, physical therapy, NSAID's, etc.), neither is there any evidence of a progression of neurological deficit due to this presumed median nerve entrapment over these 16 months.
2. Her symptoms are in both hands. She is right-handed. Neurological evaluation on 7/03/01 revealed minimal abnormalities. The Tinel's sign was said to be positive in both hands. Abductor pollicis brevis strength is rated 4/5 by the examiner. Electrodiagnostic testing shows "moderate bilateral median sensory neuropathy." Follow-up clinical testing suggests slightly less grip strength in the left hand than right. There is no mention of significant weakness of pinch, thenar atrophy, muscle asymmetry.
3. I agree with ___ (and disagree with the physician advisor) that injection of cortisone into the carpal tunnel is not a recommended treatment in this particular case.
4. With evidence of a definite progression of symptoms and documentation of a progressive neurological deficit in one or both hands, I would not hesitate to recommend prompt surgical decompression of the carpal tunnel.
5. In my opinion, the symptoms and objective findings in this patient's hands alone do not explain why she is unable to work at her previous job; and, in my opinion, carpal tunnel release and/or left radial nerve release is unlikely to be the factor that causes her to be able to return to work.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 24 June 2002