

July 26, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0883-01
IRO Certificate No.: IRO 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 physician. Your case was reviewed by a physician reviewer who is a Chiropractor.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. The reviewer has determined there is not enough objective evidence to warrant the medical necessity of an additional three weeks of work hardening.

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 July 26, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ____, ____. I have reviewed the medical information forwarded to me concerning MDR Case File #M2-02-0883-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Peer reviews dated May 9, 2002 and May 17, 2002.
2. Office visit note from ____ from May 30, 2002, and June 6, 2002.
3. Initial report from ____, dated June 7, 2001.
4. Work hardening daily notes from April 15, 2002, to May 3, 2002.
5. FCE's from April 3, 2002, and December 4, 2001.
6. EMG/NCV test from May 3, 2001.
7. MRI of the right wrist, dated December 12, 2001.
8. MRI of the cervical spine, dated June 14, 2001.

B. BRIEF CLINICAL HISTORY:

The patient, while working as a customer service representative for ____, felt tingling, pain and numbness in both wrists. She was seen by ____ and referred for diagnostic testing that showed she had carpal tunnel syndrome in the right wrist. Surgery was performed on July 14, 2001. The patient underwent post-surgical rehab, completing a chronic pain management program and three weeks of work hardening.

C. DISPUTED SERVICES:

Additional three weeks of work hardening.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

There is no definitive objective clinical evidence that the claimant has progressed in three weeks of the work hardening program. ____ states in her letter of May 16, 2002, that the patient has made some progress in range of motion and strength, and symptoms have decreased. These objective findings were not backed up by clinical evidence such as range of motion figures, grip strength measurements, pain scale levels, etc. If these figures were obtained and available for review, they could be compared to the FCE of April 3, 2002, in order to show the measurable progress that the patient obtained in the three weeks of work hardening.

In short, there is not enough objective evidence to warrant the medical necessity of an additional three weeks of work hardening for this patient.

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 July 2002