

July 1, 2003

MDR Tracking #: M2-03-1370-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Neurological Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

On ___, this 53-year-old female patient noted the gradual onset of left hand pain, weakness and paresthesias while working as an administrative specialist. Conservative treatment including therapy, a left wrist injection and a wrist splint failed to alleviate this syndrome. EMG testing revealed only mildly decreased recruitment in the abductor pollicis brevis. All other EMG testing was normal. Upon examination, her strength was 4/5 at left thumb opposition and her sensation to pin prick was diminished through the left upper extremity. Tinel's sign was positive at both wrists.

REQUESTED SERVICE

Neuroplasty of the median nerve at the left carpal tunnel is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The decision with regards to ___ is that the proposed neuroplasty of the median nerve at the left carpal tunnel is indeed medically necessary. Treatment guidelines and care standards would indicate that in a patient who has sustained a carpal tunnel syndrome as the result of repetitive occupational exposure (as this patient has) and who has failed to respond to conservative management, including occupational therapy, injections and splinting, with supportive EMG evidence for a diagnosis of carpal tunnel syndrome and focal motor weakness, should undergo surgical correction of carpal tunnel syndrome. Such is the case with this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).