

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1671-01

September 15, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in surgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

___ is a 46-year old male who was injured on ___ while lifting a radiator out of a vehicle while employed by ____. Patient complains of a mile carpal tunnel, which has not responded to conservative treatment.

REQUESTED SERVICE(S)

Left carpal tunnel release, dorsal capsule exploration and excision of the posterior interosseous nerve.

DECISION

Uphold previous denial.

RATIONALE/BASIS FOR DECISION

All material presented has been thoroughly reviewed which included Exhibit 1, Preauthorization Denial Rationale, and Exhibit 2, copy of medical records provided with the request. Reports and notes were made available from rehab physicians and requesting surgeon, however, there is no good indication for the services requested.

1. The requesting doctor has had many opportunities to submit further documentation to support this request after the denial, but has failed to do so.
2. The present records lack appropriate documentation relating the interosseous nerve and capsular indication involvement to the patient's original injury. Slight falls with no obvious fractures postoperatively, despite the weakness in the legs, is not enough to relate his current conditions to his injury.

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) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 15th day of September 2003.