

September 17, 2004

Mrs \_\_\_\_

**RE: MDR#:** M2-04-1836-01      **Injured Employee:** \_\_\_\_  
**TWCC#:** \_\_\_\_      **DOI:** \_\_\_\_  
**IRO Certificate #:** 5055

**TRANSMITTED VIA FAX TO:**

**Texas Workers' Compensation Commission**  
Medical Dispute Resolution  
Fax: 512-804-4868

**RESPONDENT:**

Healthsouth Corp. c/o Ace USA/ESIS  
Attn: Javier Gonzalez  
Fax: (512) 394-1412

**TREATING DOCTOR:**

Mark Laning, D.C.  
Fax: (972) 554-4665

John B. Payne, D.O.  
Fax: (817) 868-9500

Dear Ms. \_\_\_\_:

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

I am the Secretary and General Counsel of Independent Review, Inc., 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 care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is board certified in Orthopedic Surgery and is currently listed on the TWCC Approved Doctor List.

## REVIEWER'S REPORT

### Information Provided for Review:

TWCC-60, Table of Disputed Services, EOBs

Information provided by Respondent:

- Required medical exam 12/08/03 & 11/22/03
- Designated doctor exam 10/10/03

Information provided by Treating Doctor:

- Letter of medical necessity 08/11/04
- Office notes and consultations 07/03/02 – 04/13/04
- Physical therapy note 09/18/03
- ROM measurements 10/31/02 thru 05/20/03
- NCV 04/02/04, 10/04/02, 09/04/02
- Operative report 03/06/03
- MRI 08/21/02

Information provided by Neurosurgeon:

- Office notes 02/20/04 – 07/12/04

### Clinical History:

The patient developed chronic left hand pain, numbness, weakness and recurrent swelling and pain of the left forearm as a result of work-related injury on \_\_\_\_\_. EMG and NCV studies dated September 4, 2002 failed to demonstrate carpal tunnel syndrome.

### Disputed Services:

Left carpal tunnel release.

### Decision:

The reviewer agrees with the determination of the insurance carrier and is on the opinion that left carpal tunnel release is not medically necessary in this case.

### Rationale:

Electro diagnostic studies have failed to confirm the clinical impression. A steroid injection into the carpal canal may resolve this patient's problem. If the problem then recurs, there is indication for carpal tunnel release.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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 the right to request a hearing.

**If disputing a prospective spinal surgery decision**, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admn. Code 142.5c).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admn. Code 148.3).

The decision is deemed received by you five (5) days after it was mailed (28 Tex. Admn. Code 142.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

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 US Postal Service from this IRO office on September 17, 2004.

Sincerely,

Gilbert Prud'homme  
Secretary & General Counsel

GP/thh