

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-1538.M2**

NOTICE OF INDEPENDENT REVIEW DECISION

Date: October 23, 2003

RE: MDR Tracking #: M2-04-0001-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

According to the supplied documentation, it appears that ___ sustained an injury to her right forearm, wrist, and hand on ___. The claimant had multiple diagnostic tests performed and then had surgery 03/27/2003. ___ performed the surgery and gave her a postoperative surgery diagnosis of right carpal tunnel syndrome, right pronator syndrome, right radial tunnel syndrome and right cubital tunnel syndrome. On 07/14/2003, the claimant had an evaluation performed at ___ that revealed relatively normal ranges of motion, but reported diminished muscle strength in all areas tested. A letter from ___ reported that the claimant needed a work hardening program. A note by ___ on 07/30/2003 stated that he felt the claimant would be a good candidate for a work hardening program. The documentation ended here.

Requested Service(s)

Please review and address the medical necessity of the requested work hardening program.

Decision

I agree with the insurance company that the work hardening program is not medically necessary.

Rationale/Basis for Decision

According to the supplied documentation, it appears that the claimant has deficits in muscle strength associated with her compensable injury. The report dated 07/14/2003 states that the claimant has muscle strength of 2/5 in all ranges of motion in her right wrist and elbow. A 2/5-muscle strength is defined as complete range of motion with gravity removed. The test performed at ___ does not state how the test was performed, but is a difficult finding to assess. In my professional opinion, a grade 2/5 is very unlikely without a severe neurological deficit, which is not documented. On the claimant's unaffected elbow and

wrist, a grade 3/5 was given. A 3/5 is defined as complete range of motion with gravity, but with no resistance. Since this extremity was not affected a 3/5 is also a highly unlikely finding and would generally be related to the claimant not giving full effort during the test. Since the treating doctor has recommended a strengthening program, this claimant would benefit from a home exercise program that would include therapy putty, a hand spring and theraband to help regain strength. There was no objective documentation supplied that would indicate work hardening lasting 8 hours a day for 20 visits would be warranted in this claimant's condition.

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) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

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) 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 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

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

This decision by the IRO is deemed to be a TWCC decision and order.