

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0126-01

October 15, 2003

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic 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 \_\_\_.

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### CLINICAL HISTORY

\_\_\_ on \_\_\_ alleges an injury to his neck, right shoulder, elbow and right wrist and hand. For the better part of two to three years, he was treated by \_\_\_\_, \_\_\_ and \_\_\_ regarding these injuries. \_\_\_\_, his orthopedist, documents bilateral shoulders, elbow, neck problems with conservative failures to treat the elbow and shoulder even per injection techniques. \_\_\_ performs an ACF C4-5 with residual symptoms.

In May and June 2003 \_\_\_ sees the patient briefly, notes a "nine month history" of right shoulder, right elbow, right wrist problems. He performs injections on several of these body parts and concludes on 6/17/03 that he needs concomitant surgery to the right shoulder, right elbow, excision of the ganglion of the right wrist, and carpal tunnel release.

## REQUESTED SERVICE(S)

Medical necessity of proposed ganglionectomy and repair rotator cuff, excision distal clavical lateral epicondylar release and carpal tunnel release.

## DECISION

Deny procedures.

## RATIONALE/BASIS FOR DECISION

Based upon the medical history and especially the treatment rendered \_\_\_ in 2002 and 2003, the carrier's position should be upheld. \_\_\_, for the better part of three and a half years has presented as a failed treatment regimen of multiple surgical procedures and proceeding with the surgery as requested would be yet another recipe for failure.

The opinions rendered in this case are the opinions of the evaluator. This evaluation has been conducted on the basis of the medical documentation provided with the assumption that the material is true, complete, and correct. If more information becomes available at a later date, then additional services, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided.

### **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 20<sup>th</sup> day of October 2003.