

December 10, 2003

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TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-0479-01
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 Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). 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

Available documentation states that this patient reports a repetitive work injury involving her neck, left shoulder and left wrist from ___. She presented initially to her chiropractor, ___, on 4/18/03 for conservative treatment that included x-rays, diagnostic tests and both active and passive physical medicine modalities. The patient also received pain management evaluations and treatment with ___ beginning 8/28/03. Her x-rays were found essentially normal with some minimal focal disc protrusion on her cervical CT. No orthopedic or neurodiagnostic evaluations appear to be performed. The patient began a work conditioning program for fifteen sessions between 9/4/03 and 10/30/03. Treating chiropractors, ___ and ___ performed an impairment evaluation on 9/18/03 that found the patient at MMI with 12% whole person residual impairment. A designated doctor evaluation performed on 9/25/03 by ___ suggested that this patient had not achieved MMI and that EMG and NCV and orthopedic evaluation was indicated in order to properly identify the status of her work-related conditions. On 10/24/03, her chiropractic office requested three additional weeks of work conditioning.

REQUESTED SERVICE

Three additional weeks of work hardening are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The designated doctor evaluation of 9/25/03 suggests that EMG, NCV and orthopedic consultations would be indicated prior to determining ongoing treatment necessity and final determination of MMI.

Hadler NM: Illness in the workplace: the challenge of musculoskeletal symptoms. J Hand Surg Am 10:451-456, 1985.

Nathan PA, Meadows KD, Doyle LS. Occupation as a risk factor for impaired sensory conduction of the median nerve at the carpal tunnel. J Hand Surg Br. 1988; 13:167-170.

Phalen GS. The carpal tunnel syndrome. Seventeen years experience in diagnosis and treatment of 654 hands. J Bone Joint Surg Am 1966;48:211-228.

Phalen GS. The carpal-tunnel syndrome. Clinical evaluation of 598 hands. Clin Orthop. 1972;83:29-40.

___ 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 ___, 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 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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

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.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 10th day of December 2003.