

May 12, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

### MDR Tracking #: M2-04-0997-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in orthopedic surgery and is familiar with the condition and treatment options at issue in this appeal. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 45 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he was lifting a machine and it fell onto his arm. A MRI of the right elbow performed on 1/30/02 was reported to be normal. On 2/6/02 the patient underwent an EMG that was reported to show fine instances of an ulnar nerve lesion at the elbow. The patient underwent an ulnar nerve release on 5/2/02. The current diagnoses for this patient includes right cubital tunnel syndrome, status post surgery, and chronic regional pain syndrome, right upper extremity and ulnar nerve injury. Treatment for this patient's condition has included medications, physical therapy, exercises, and ganglion blocks. The patient is being referred for a single lead percutaneous stimulator trial with fluoroscopy.

#### Requested Services

Single Lead Percutaneous Stimulator trial with fluoroscopy

#### Documents and/or information used by the reviewer to reach a decision:

##### *Documents Submitted by Requestor:*

1. Office notes 10/31/02 – 4/23/04
2. Medical Necessity Letter 3/10/04, 4/28/04

##### *Documents Submitted by Respondent:*

1. MMI 2/26/04

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 45 year-old male who sustained a work related injury to his arm \_\_\_\_. The \_\_\_ physician reviewer noted that the patient underwent an ulnar nerve release on 5/2/02 and has been further treated with medications, physical therapy, exercises, and ganglion blocks. The \_\_\_ physician reviewer indicated that the patient has been referred for further treatment with a percutaneous stimulator. The \_\_\_ physician reviewer explained that the patient's history and exam are consistent with RSD status post ulnar nerve problems despite surgical release. The \_\_\_ physician reviewer also explained that the patient has tried and failed treatment with Neurontin, narcotics and ganglion blocks. The \_\_\_ physician reviewer further explained that a spinal cord stimulator is a known treatment for RSD and is clearly indicated for this patient's condition. Therefore, the \_\_\_ physician consultant concluded that the requested single lead percutaneous stimulator trial with fluoroscopy is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

**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. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

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

**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. (Commission Rule 133.308(t)(2))

Sincerely,

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 12<sup>th</sup> day of May 2004.