

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

June 9, 2004

**Re: IRO Case # M2-04-1330**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who is a fellowship trained hand surgeon, and who has met the requirements for the TWCC Approved Doctor List or who has been granted an exception from the ADL. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed services
2. Denial letters
3. Peer reviews 2/15/04, 2/13/04
4. Psychological evaluation 2/5/04
5. Request for reconsideration 4/2/04
6. Medical narrative 3/14/04, 1/17/04
7. Work hardening and physical therapy progress notes
8. FCE report 3/22/04
9. NCS report 6/27/03

- 10. Muscl Skeletal report 6/17/03
- 11. D.C. consultation note 21/8/03

History

The patient is a 43-year-old female with chronic bilateral upper extremity pain, who was diagnosed with carpal tunnel syndrome electrodiagnostically. The patient received extensive non-operative physical therapy and chiropractic manipulation. The extensive medical records provided for review do not indicate that the patient has had any steroid injections into the carpal tunnel as either diagnostic or therapeutic maneuvers. There is no documentation of any surgical consultation provided.

Requested Service(s)

Work hardening program 5x week for 3 weeks

Decision

I agree with the carrier's decision to deny the requested treatment.

Rationale

Eleven months of conservative care is excessive for a patient with mild to moderate bilateral carpal tunnel syndrome. The records indicate that the patient failed non-operative treatment, and would require surgical management. If the patient opts not to proceed with surgical treatment, then she would be at MMI. The patient, after this long in conservative treatment, is not a candidate for continued physical therapy or work hardening. Eleven months of conservative treatment is more than enough to allow the patient to regain strength, range of motion and the ability to return to work. The medical documentation provided for this review does not justify or support the rationale for a work hardening program, and its medical necessity was not established. Work hardening programs are generally not appropriate for mild to moderate carpal tunnel syndrome.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

**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.

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 10<sup>th</sup> day of June 2004.