

August 16, 2004

Re: MDR #: M2-04-1627-01  
IRO Certificate# 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in the area of Chiropractic Medicine and is currently listed on the TWCC Approved Doctor List.

### **REVIEWER'S REPORT**

#### **Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes, FCE, electrodiagnostic test and radiology report.

Information provided by Respondent: correspondence and designated doctor exam.

#### **Clinical History:**

The claimant was diagnosed with carpal tunnel syndrome in both wrists on \_\_\_\_\_. She received carpal tunnel release to the right wrist on November 5, 2003, and to the left on January 21, 2004. She then underwent at least four weeks of physical therapy. She was given an impairment rating of 6% and assigned maximum medical improvement on May 15, 2004.

#### **Disputed Services:**

Work hardening program

#### **Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that a work hardening program is not medically necessary in this case.

**Rationale:**

Based on the documents provided, four weeks of work hardening is not the best course of treatment for this patient. Her records show pain-focused complaints and a lack of maximum effort by the patient to improve as evidenced by the history of non-compliance by the first treating doctor. Undoubtedly, there exists a large psychosomatic component to her recovery that should be addressed separately. A full regimen of work hardening is not appropriate at this time without the patient's psychological issues being addressed and her attentions re-focused to getting better. There is no reason to expect a positive response from work hardening when previous physical therapy showed some positive results, even though the patient stated otherwise until confronted and pressured by the doctor to confirm his objective findings. Unless there is an undiagnosed cause for her continued pain, there is no physical reason she should not be improving, especially when both surgeries were reportedly successful and without post-operative complications.

Furthermore, based on the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, chapter 8 pages 124-125, patients who have received passive and active care and continue to be unresponsive should be considered as inappropriate for continued chiropractic care, or having reached maximum therapeutic benefits. Additionally, prolonged symptoms past 16 weeks after active therapies may also indicate maximum medical improvement has been reached, suggesting an alteration to her lifestyle would be necessary because pre-injury status may not return.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) 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  
Texas Workers' Compensation Commission, MS-48  
7551 Metro Center Dr., Ste. 100  
Austin, TX 78744-1609

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.

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 August 16, 2004.