

## NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

**Date:** October 7, 2004

**RE: MDR Tracking #:** M2-05-0048-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an orthopedic surgeon reviewer (who is board certified in orthopedic surgery) who has an ADL certification. The physician reviewer has signed a certification statement stating 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 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 this case.

### **Submitted by Requester:**

- None submitted.

### **Submitted by Respondent:**

- Clinic reports by \_\_\_ from 11/18/02 through 06/30/04.
- Clinic reports from \_\_\_, chiropractor, 11/07/02 through 03/11/03.
- MRI reports, left shoulder, 10/31/02
- Operative notes by \_\_\_ on 2/6/03 for left shoulder arthroscopy and arthroscopic shoulder decompression.
- MRI report of right wrist 2/13/03
- MRI report of left wrist 2/13/03
- Electrodiagnostic studies on 12/4/02

### **Clinical History**

On \_\_\_ the claimant reported her injury while working for \_\_\_. Her job duties consisted of stocking and filling the boxes with books to be distributed \_\_\_. The weight of the boxes was between 50 to 70 pounds. She noted discomfort in her left shoulder and bilateral wrist pain and was treated with chiropractic manipulations by \_\_\_. On 10/31/02 MRI of the left shoulder

showed advanced tendinosis and partial tear of the rotator cuff without evidence of full thickness tear. On 11/18/02, \_\_\_ noted the patient to have left shoulder rotator cuff impingement. \_\_\_ performed a subacromial steroid injection. On 2/6/03, \_\_\_ performed left shoulder diagnostic arthroscopy and arthroscopic shoulder decompression. On 2/13/03 MRI of the right wrist showed 1 cm ganglion cyst at the volar carpal radial joint. On 2/13/03 MRI of the left wrist showed small volar and dorsal ganglion cyst. On 6/11/03 MRI of the left shoulder showed rotator cuff tendinopathy without full thickness tear. On 9/24/03 \_\_\_ felt the claimant to be not at maximum medical improvement due to continued pain and numbness in both of her hands. On 8/28/03 EMG and nerve conduction studies showed neuropathy at the wrists bilaterally consistent with mild carpal tunnel syndrome. There was evidence of demyelination without evidence of axonal degeneration. The claimant recovered well from her left shoulder surgery with therapy regaining her range of motion and function. On 8/18/03 \_\_\_ noted the claimant reported symptoms of bilateral carpal tunnel syndrome. Her clinical exam was positive for positive Tinel's and positive Phalen's bilaterally. \_\_\_ continued to follow the patient for her bilateral carpal tunnel syndrome. On 6/2/04 \_\_\_ noted the claimant was status post right carpal tunnel release. There is no operative report available for review. Postoperatively the claimant had good relief of her symptoms on her right wrist. On 6/30/04 she had mild hypersensitivity over the operative site and good resolution of her symptoms. \_\_\_ recommended proceeding with the left carpal tunnel release.

### **Requested Service(s)**

Left carpal tunnel release.

### **Decision**

I agree with the provider that the services requested are medically necessary.

### **Rationale/Basis for Decision**

The claimant reported her symptoms onset on \_\_\_\_. Her job duties included repetitive heavy lifting and filling boxes with books weighing approximately 50 to 75 pounds. She reported symptoms to her left shoulder and bilateral wrists. Her left shoulder had been treated appropriately with surgical treatment. Her bilateral wrists symptoms continued with symptoms of numbness and pain, clinical exam positive for positive Tinel's and positive Phalen's, and EMG nerve conduction studies consistent with bilateral mild carpal tunnel syndrome. The claimant had symptoms, clinical exam and electrodiagnostic studies consistent with bilateral carpal tunnel syndrome. Her symptoms as reported are related to the injury as reported on \_\_\_\_. The claimant however did not have good documentation of trial of non-operative treatments to include: splinting, carpal tunnel injections. However, given the duration of her symptoms, positive clinical exam and electrodiagnostic studies consistent with bilateral carpal tunnel syndrome, she is a candidate for left carpal tunnel release.

### **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 (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.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 7<sup>th</sup> day of October 2004.