

December 14, 2004

Re: **MDR #:** M2-05-0324-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Attention: Rosalinda Lopez
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT:

Ysleta ISD
Attention: ____
(512) 452-7004

Claims Administration Services
Attention: ____
(915) 591-5058

TREATING DOCTOR:

Dr. D, M.D.
(915) 591-0962

Dear ____:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 Independent Review, Inc. 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 Board Certified in Physical Medicine and Rehabilitation and in Pain Management and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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 December 14, 2004.

Sincerely,

Secretary & General Counsel

GP/thh

REVIEWER'S REPORT
M2-05-0324-01
12/14/04

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Respondent:

- Correspondence
 - Physician advisor determinations 09/08/04 & 09/24/04
- Information provided by Treating Doctor:
- Office notes 05/05/04 – 10/27/04
 - FCE 09/16/04
 - Nerve conduction study 02/17/04
 - Operative report 06/24/04

Clinical History:

The patient sustained a repetitive motion injury with a date of injury of _____. Her injuries specifically included right carpal tunnel syndrome and flexor tenosynovitis with triggering of the right thumb. She was subsequently operated on for these conditions on or about 6/24/04.

Disputed Services:

Work conditioning program.

Decision:

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

Rationale:

The patient underwent 2 months of physical therapy following her operation. This should have provided more than adequate rehabilitation. A functional capacity evaluation performed on 9/16/04 revealed grip strength measurements on the right of 10 pounds and below, although the distance involved with the grip measurements was apparently increased (as in Jamar Dynamometry). The right hand failed to produce a bell-shaped curve or any close resemblance to same. It has been well established that even in the face of weakness, a bell-shaped curve should be produced given the length/tension relationships of the muscle with progressively increasing grip distance. I, therefore, question the validity of effort during this test period. All of the above considered, I do not believe the patient has appropriate indications for a work-conditioning program given her occupation of cashier.