

April 12, 2005

Re: **MDR #:** M2-05-0963-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission

Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:

Charles Neagle, M.D.
Attention: Tracy
(972) 492-7909

RESPONDENT:

Alea North America Ins. Co.
Attention: Robert Josey
(512) 346-2539

Dear Mr. ____:

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 Orthopedic Surgery 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 April 12, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/thh

REVIEWER'S REPORT M2-05-0963-01

Information Provided for Review:

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

Information provided by Requestor:

Office notes 08/19/04 – 11/23/04

FCE 06/16/04

Electrodiagnostic studies 07/16/04 – 08/31/04

Information provided by Respondent:

Correspondence

Information provided by Chiropractor:

Office notes 05/19/004 – 07/30/04

Daily progress notes 05/20/04 – 08/13/04

Fitness flow sheet 06/18/04 – 08/13/04

Clinical History:

The patient is a 64-year-old right-handed-dominant male who was treated for bilateral anterior interosseus nerve syndrome following work-related injury on or about on _____. He was treated initially with chiropractic treatment and eventually referred for electrodiagnostics, which demonstrated significant neuropathy of the anterior interosseus nerve, as well as mild bilateral carpal tunnel syndrome.

Disputed Services:

Right anterior interosseous nerve release @ forearm, right median release @ forearm, right carpal tunnel release, right hand internal neurolysis.

Decision:

The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that right median nerve release in the forearm, and right hand internal neurolysis are not medically necessary. Right anterior interosseous nerve release at forearm, and right carpal tunnel release are medically necessary in this case.

Rationale:

With regard to the proposed surgical procedures for this patient, the proposed right anterior interosseus nerve release and carpal tunnel repair are medically necessary and appropriate procedures. However, the right median nerve release in the forearm is included in the right anterior interosseus nerve release and is not a separate entity and cannot be approved. Finally, in the absence of previous surgery or open wounds, an internal neurolysis is not medically necessary or indicated for this patient.

Screening Criteria/Treatment Guidelines/Publications Utilized:

Green's Operative Hand Surgery textbook.