

May 10, 2005

**Re: MDR #:** M2-05-1278-01  
**TWCC#:**  
**IRO Cert. #:** 5055

**Injured Employee:**  
**DOI:**  
**SS#:**

**TRANSMITTED VIA FAX TO:**

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

**REQUESTOR:**

Warren D. Parker, MD  
Attention: Dawn  
(713) 797-6264

**RESPONDENT:**

Continental Casualty Co.  
Attention: D. Womack  
(214) 220-5614

**TREATING DOCTOR:**

Robert Lindsey, MD  
(936) 634-8800

Dear Ms. \_\_\_\_

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, training and specializing in the area of Upper Extremity Orthopedics, 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 May 10, 2005.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP/thh

### REVIEWER'S REPORT M2-05-1278-01

#### Information Provided for Review:

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

Information provided by Requestor:

Office notes 09/07/04 – 01/17/04

Electrodiagnostic study 02/18/02 – 01/29/04

Operative report 11/18/04

Radiology reports 03/18/03 – 11/18/04

Information provided by Respondent:

Correspondence

Designated doctor reviews

Information provided by Orthopedic Surgeon:

Office notes 10/23/03 – 12/10/04

Procedure report 03/24/04

**Clinical History:**

The claimant is a now 40-year-old female who underwent successful right 5/6, 6/7 partial hemilaminectomy and decompressive foraminotomy for spondylitic stenosis. She has complained consistently, according to the records submitted, since the time of the initial record available from 12/05/03 of numbness and tingling in the right hand consistent with carpal tunnel syndrome. She has undergone EMG and nerve conduction studies, also indicative of carpal tunnel syndrome.

According to the records submitted, the patient has complained of symptoms consistent with carpal tunnel syndrome since at least \_\_\_\_\_. The only record made available for review prior to this date was one of 10/23/03. Her complaints per the evaluation performed by her treating doctor on 12/05/03 included pain, numbness, and tingling radiating into the hands. She subsequently underwent EMG and nerve conduction studies on 01/29/04, which showed evidence of median neuropathy at the right wrist. She has previously received a corticosteroid taper with minimal improvement, as is clearly outlined in the treating doctor's office note of 12/10/04. She exhibited diminished sensation in the thumb, index, middle and radial aspect of the ring finger on the right with otherwise normal sensation throughout the right and left upper extremities

**Disputed Services:**

Carpel tunnel decompression – right hand.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that carpal tunnel decompression of the right hand is medically necessary in this case.

**Rationale:**

In view of the clearly documented physical findings, as well as electrodiagnostic findings and failure of conservative management, surgical intervention would be indicated at this point.

**Screening Criteria; treatment guidelines; publications utilized:**

As references, the reviewer include Operative Hand Surgery, Green, 3<sup>rd</sup> Edition, Chapter 36, "Entrapment Compression Neuropathies," page 1347, paragraph 3: "One indication for operative intervention in the carpal tunnel is the failure to respond to conservative therapy. Conservative therapy for median neuritis consists of splinting of the wrists, injection with corticosteroid into the carpal tunnel, and oral non-steroidal anti-inflammatory medications."