



## IMED, INC.

1819 Firman • Suite 143 • Richardson, Texas 75081  
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584  
e-mail: imeddallas@msn.com

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### NOTICE OF INDEPENDENT REVIEW

**NAME OF EMPLOYEE:**  
**IRO TRACKING NUMBER:** M2-06-1900-01  
**NAME OF REQUESTOR:** Texas Health / Phil Bohart  
**NAME OF CARRIER:** St. Paul / Travelers / Target Corp  
**DATE OF REPORT:** 09/03/06  
**IRO CERTIFICATE NUMBER:** 5320

#### TRANSMITTED VIA FAX:

IMED, Inc. has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO).

In accordance with the requirement for TDI to randomly assign cases to IROs, TDI has assigned your case to IMED, Inc. for an independent review. The peer reviewer selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the peer reviewer reviewed 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.

The independent review was performed by a matched peer with the treating physician. This case was reviewed by a chiropractic physician reviewer who is Board Certified in the area of Chiropractic Medicine and is currently listed on the DWC approved doctor list.

I am the Secretary and General Counsel of IMED, 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 the provider, the injured employee, injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. I further certify that no conflicts of interest of any nature exist between any of the aforementioned parties and any director, officer, or employee of IMED, Inc.

#### REVIEWER REPORT

I have reviewed the records forwarded on the above injured worker and have answered the questions submitted.

**Information Provided for Review/Clinical History Summarized:**

1. Notice of IRO assignment.
2. Correspondence from Constitution State Services.
3. Employer's First Report of Injury or Illness.
4. 08/19/04 – Additional evaluation with Bruce R. Beavers, M.D., who indicated the employee was a 43 year old female reporting popping in her right wrist with pain, bilateral numbness and paresthesia greater on the right side affecting all digits attributed to repetitive motion. Dr. Beavers established an assessment of carpal tunnel syndrome and radial styloid tenosynovitis, and a corticosteroid injection was performed.
5. Office notes from 12/27/04 through 03/08/05. This documentation indicated that the employee was not significantly changed, she was wearing a splint and working, and surgical intervention was considered.
6. 01/24/05 – Office visit with Bruce Beavers, M.D. The report indicated that the employee had an injection by Dr. Doyle but continued to experience slight swelling in her wrist. There was an impression of status post carpal tunnel release with a diagnosis called carpal tunnel syndrome.
7. 02/08/05 – Facsimile transmission from Rockwall Physical Therapy indicating a diagnosis of de Quervain's tenosynovitis and carpal tunnel syndrome. It was indicated that the employee attended fifty scheduled physical therapy treatment sessions consisting of manual stretching techniques, joint mobilization, ultrasound, paraffin, ice, electrical stimulation, acupuncture, and instruction on an in-home exercise program. The report goes on to state that the employee was not progressing despite all these efforts. It appeared he was continuing to work at the time of this report.
8. 03/25/05 – Report from Rehabilitative Medicine Associates. This report was provided for review and is apparently incomplete.
9. 03/29/05 Thru 11/07/05 – Documentation for thirteen office visits. The notes indicated that the employee underwent electrodiagnostic studies on 03/25/05 which revealed persistent delay in the right median nerve at the wrist. The report also indicated that the employee would have surgical intervention for this diagnosis. On 09/06/05, the chart notes indicated that the employee was five months postoperative and continued to experience right carpal tunnel and left carpal tunnel symptoms. It was reported that she was wearing canvas cock-up splints, and her left distal forearm and wrist were swollen. She was injected on this date with Marcaine. On 11/07/05, it was documented that the employee returned early as an occupational therapist apparently noted subluxation in her wrist on evaluation. X-rays revealed a marked volar tilt in the lunate, and it was indicated that the problem would probably require an arthrodesis. On 03/25/05, nerve conduction studies of the upper extremities revealed abnormal findings consistent with right carpal tunnel syndrome. On 04/01/05, an operative report from Michael Doyle, M.D., indicated a right carpal tunnel

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release, internal saline neurolysis of the median nerve, release of the first extensor compartment, and excisional arthroplasty of the trapezium.

03/17/05 - Required Medical Evaluation (RME) report from David Willhoite, M.D., indicated the employee would require release of the first dorsal compartment of the right wrist for treatment of the de Quervain's tenosynovitis and a possibility that she could have a recurrent carpal tunnel syndrome of the right wrist. It was recommended by Dr. Willhoite that the employee repeat her electrodiagnostic studies.

04/01/05 – Follow-up report with Dr. Willhoite indicated that the employee could return to work with light duty restrictions of no repetitive use of the upper extremities.

09/26/05 – RME with Dr. Willhoite indicated that since his initial examination, the employee had a carpal tunnel release by Dr. Beavers on 10/05/04. Dr. Willhoite indicated the employee changed treating doctors to Dr. Doyle, who was recommending surgery consisting of release of the first dorsal compartment, surgery on the trapezial metacarpal joint, as well as a repeat right carpal tunnel release. The report indicated the employee had surgery on her right wrist in April, 2005 consisting of release of the first dorsal compartment of the right wrist, as well as redo carpal tunnel release and arthroplasty of the trapezial metacarpal joint. A diagnosis was established of postoperative surgery right wrist and hand with continued weakness and some numbness. Dr. Willhoite indicated that ongoing treatment was reasonable and medically necessary and should consist of physical therapy for her hand and Cortisone injections.

11/29/05 – MRI report of the left wrist with the following impressions; 1) radius and ulna carpal and metacarpal bones were normal, 2) TFCC and intrinsic ligaments of wrist normal, 3) dorsal extensor tendons and palmar flexor tendons normal, 4) minimal increased signal without increased size of median nerve within carpal tunnel, 5) volar ganglion no soft tissue mass or edema. This report was presented by Rudolph H. Miller, III, M.D.

11/29/05 – An MRI of the wrist with and without contrast on the right interpreted by Rudolph H. Miller, III, M.D., to reveal the following impressions. 1) Radius and ulnar intact, prior resection trapezium, remaining carpal as well as carpal base was normal. 2) Soft tissue changes with enhancement seen in fossa formally occupied by trapezium, no fluid collection or surrounding edema to suggest infection. Given recent surgery, this is well even expected enhancement in a postoperative field. 3) TFCC and intrinsic ligaments of wrist intact. 4) Dorsal extensor tendons and palmar flexor tendons normal without tendinopathy or synovial fluid. 5) Extensor pollicis brevis and extensor pollicis, as well as abductor pollicis longus tendons pass by area of enhancement but are uninvolved. Similarly, enhancement did surround terminal portions of flexor carpi radialis tendon, but the tendon itself was

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unaffected. 6) No enhancement of the median nerve within carpal tunnel. No increased size. Prior successful carpal tunnel release with division of flexor retinaculum. Trace increased signal of median nerve within carpal tunnel not unexpected following successful carpal tunnel release. 7) No soft tissue masses or ganglia.

12/13/05 Thru 08/24/06 – Chart notes for twenty-four office visits with John Bodefuhr, D.C. There was no significant progress documented in these daily chart notes.

01/19/06 – Report from Robert Ippolito, M.D., indicated subluxation of carpal bone secondary to SPT fusion. This report indicated that it was believed that the collapse of the carpal bone was secondary to the surgery performed by Dr. Doyle. The report indicated the employee's condition was progressively getting worse, and that the deformity due to the collapse of the lunate and scaphoid was very significant.

02/06/06 – Operative report from Dr. Ippolito indicating a partial carpectomy of the scaphoid bone of the wrist fusion partial.

02/20/06 – Follow-up evaluation with Dr. Ippolito indicated this was a follow-up after surgery. The notes indicated that the deformity of the right wrist had been corrected and the employee would return in three weeks.

03/06/06 – Report from Dr. Ippolito indicated the employee was satisfied with the progress but still had significant pain.

04/24/06 – Office visit with Dr. Ippolito indicated the employee was in the office requesting treatment of recovered right wrist. It was indicated that the employee had claims on both wrists and both wrists and hands were compensable. There were no significant findings on this report.

05/22/06 – Follow-up visit with Dr. Ippolito indicated that the fusion appeared stable with no evidence of any movement. It was reported that due to continued pain, an MRI was requested.

05/25/06 – Initial behavior medicine consultation was requested due to the employee's complicated recovery and failure to return to work following her third surgery. Dr. Bodefuhr asked that the employee be assessed to determine her suitability for some level of behavioral health care. The summary of this evaluation by Tracy Duran, MS, LPC, suggests that a battery of formalized tests to include MBMD and BHI-II, as well as psychophysiological profile assessment to obtain objective baseline battery regarding her severe muscle tension and pain complaints including injury related headaches would be necessary.

06/08/06 – Advance Medical Imaging MR wrist with and without contrast right indicated the following impressions. 1) Status post resection of the trapezium. 2) Developing partial fusion to the scaphoid and capitate. 3) Edema in the lunate filling the majority of the bone, and while this may be degenerative in nature, possibly of Kienbock's to should be considered. 4) Articulation of the hamate and lunate over a 4-5 mm area, edema in the hamate adjoins this area and complex findings would be those of a hamatolunate syndrome. 5) Mild increased signal at that abnormal enhancement of the median nerve following carpal tunnel surgery.

06/19/06 – An RME with David Willhoite, M.D. Dr. Willhoite indicated that the employee would need no further physical therapy and could do home exercise strengthening and would not require any treatment of a mild left carpal tunnel syndrome.

06/26/06 – Reconsideration for behavioral health testing preauthorization request.

TWCC-69 report of medical evaluation establishing the employee at statutory Maximum Medical Improvement (MMI) with an 18% whole person impairment.

**Disputed Services:**

Items in Dispute: Preauthorization request for two (2) hours of psychological testing (MBMD and BHI-S).

**Decision:**

Psychological testing for two (2) hours MBMD and BHI-S are medically necessary.

**Rationale/Basis for Decision:**

Documentation provided for review in this case indicates that the employee has undergone at least three surgical procedures for a work related repetitive motion injury of her wrist. In light of the multiple surgical procedures and extensive postsurgical physical therapy and occupational therapy, there appears to be conclusions by the providers that the employee's condition has not significantly improved. In fact, it was documented that following the second surgery in April, 2005, there was a collapse of carpal bones in the right hand apparently as a result of the second surgical procedure. The most recent surgery was performed by Dr. Ippolito in order to repair the collapse of the second surgical procedure.

The employee has been unable to work and has apparently had to move in with a friend due to the financial complications caused by the multiple surgical procedures and her inability to work. In fact, I find the initial behavioral medicine consultation performed on 05/25/06 by Tracy Duran, MS, LPC, to be the most insightful document in this file. It is the only document that outlines the entirety of this case and gives a complete picture of the employee's clinical situation.

The report from Ms. Duran is consistent with guidelines established by the *Chiropractic Quality Assurance & Practice Parameters* proceeding to the *Mercy Center Consensus Conference* which states, "For psychosocial factors predominant in the assessment referral for counseling should be made."

This case is certainly complex, complicated, and chronic. The employee certainly meets the criteria for a chronic pain patient which would include somatic complaints to remain static longer than two to three weeks, anxiety or depression, functional or emotional disability, and family turmoil.

Therefore, on the basis of the documentation provided and in consideration of the guidelines for *Chiropractic Quality Assurance & Practice Parameters* proceeding to the *Mercy Center Consensus Conference* in 1993, the necessity for additional psychological testing as indicated above is certainly medically necessary.

The rationale for the opinion stated in this report is based on the above mentioned guidelines, record review, as well as the broadly accepted literature to include numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with IMED, Inc. is deemed to be a DWC decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An

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appeal to District Court must be filed not later than thirty (30) days after the date on which the decision that is the subject of the appeal is final and appealable.

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk  
TDI-Division of Workers' Compensation  
P.O. Box 17787  
Austin, TX 78744

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 this dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the injured worker via facsimile or U.S. Postal Service this 4<sup>th</sup> day of October, 2006 from the office of IMED, Inc.

Sincerely,



Charles Brawner  
Secretary/General Counsel