MDR Tracking Number: M5-03-0397-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that office visits and FCE were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that the office visits and FCE fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 4/15/02 to 9/17/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 21st day of April 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 15, 2003

Requester/ Respondent Address : Rosalinda Lopez
TWCC
4000 South IH-35, MS-48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-0397-01
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 physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon 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.

Clinical History

The first record I have available is dated 4/26/02 from the Doctor which was basically a review of medical records and opinion. He did not evaluate or examine the claimant. He noted in his report that there was a first noted problem on___, indicating "that while picking merchandise felt pain in both hands". On 1/2/02 she returned to work with restrictions by the Doctor. She was noted to have been symptomatic in the bilateral wrists and elbows. On 1/16/02 there is a note from another docotor indicating that the claimant had wrist tenderness with decreased range of motion and positive Tinel's sign. Impression was probable bilateral carpal tunnel syndrome. Therapy and medications were prescribed. Follow up on 1/29/02 reiterated these findings. Therapy notes from January 2002 were briefly reviewed and work status was recommended. A note on 2/27/02 in the Doctor's report revealed that the electrodiagnostic studies revealed no electrodiagnostic evidence of medial or ulnar neuropathy bilaterally on today's EMG/NCV studies, specifically no evidence of carpal tunnel syndrome. No evidence of cervical radiculopathy bilaterally on these studies. The patient noted that the pain is fairly constant and varies between moderate and severe. In the Doctor's analysis he felt that there was not sufficient objective evidence in his review of the records to substantiate her complaints and that these findings did not appear to be compatible with carpal tunnel or ulnar neuritis, median or lateral epicondylitis, nor tenosynovitis. He did not feel that any further active ongoing medical treatment was indicated or causally related to the ___ date of injury. He felt that the claimant had a thorough diagnostic and therapeutic work up and that the claimant had subjectively failed all forms of medical treatment. He felt the claimant did appear to have the effects of a compensable work injury to have essentially resolved as, again, the claimant's marked symptomatology and inexplicable lack of response to all forms of medical treatment does not match the overall findings and the mechanism of injury that would suggest, at most, a self limited condition.

There is a report of the other doctor dated 7/8/02 to where he submitted a formal medical dispute. There are reports of hand specialists and orthopedists who had done IMEs and felt the patient did have a problem that needed to be addressed further.

There are handwritten notes from the other doctor starting on 1/16/02 extending through November 2002, which I have reviewed. A second EMG/NCV had been recommended during the course of this report. A note of 8/10/02, the other doctors handwritten notes, said that the claimant had EMG 8/20/02 by the doctor and assessment was probable cubital tunnel/carpal tunnel syndrome.

I then have reports of FCEs done, the note is by the other doctor, it seems to be from his office. The first one done 3/20/02 where she rated in the sedentary category for leg lift, torso lift, arm lift, high-near lift and the dynamic lifting capacity report placed her in light category. Her hip strength was low.

The second report, dated 5/9/02 from the other doctor functional capacity examination states that she rated in the sedentary category for leg lift, torso lift, arm lift and high-near lift.

There is a dictated note from the doctor of plastic reconstructive hand and cosmetic surgery. He says she began to notice pain and numbness down the ulnar side of the hand down into the fifth and fourth fingers since December of last year and this had not improved. On exam she has marked Tinel's sing of the medial epicondyle which elicits her symptoms down the forearm and hand. I feel that she has a

compression of the ulnar nerve at that site and she would like to have this corrected, if possible. Arrangements are being made to have the right one done first on an outpatient basis under general anesthesia.

There is a report of a doctor, board certified neurologist, dated 5/1/02. His history states that the examinee is a woman who while in the course of her normal duties working as an order processor began developing pain in both hands and wrists. She states that her hands cramped up and the pain apparently radiated to her elbows. She says she told her supervisor and her supervisor simply told her to slow up. The problem continued in December and she was referred to human resources, given ice packs, and saw a company physician who gave her anti-inflammatory medication, first Celebrex and then a trial of Daypro along with her bilateral wrist splints to wear and she was place on restricted duty.

She changed to the doctor in January. The doctor diagnosed probable bilateral carpal tunnel syndrome based on a positive Tinel's over both wrists with decreased range of motion. Relafen was prescribed as well as Carisoprodol and Vicodin. She continued to work when she was able with the imposed restrictions. She continued to complain of pain described as tingling and aching in her hands and arms, fairly constant pain with tingling involving all of the digits, apparently with numbness in the left fourth and fifth digits. She had an EMG/NCV study done by the doctor on 2/27/02. The doctor describes having found no electrodiagnostic evidence of median or ulnar neuropathy bilaterally. However, the ulnar sensory distal latencies are borderline in on-inching technique done across the elbow, especially on the left where comparing the conduction velocities showed a minimal difference. In addition, the median motor distal latencies would be considered delayed and borderline inmost labs and there was no palm to wrist sensory conduction velocity calculated. No evidence of cervical radiculopathy. Subsequently, she was set up to see the doctor, who was to see her in April. The patient had an FCE done on or about 3/19/02 and it appears to have revealed decreased wrist range of motion as well as significantly decreased grip strength. She saw the doctor on 4/4/02 and he felt she had what appeared to be ulnar nerve compression. Examination on that day revealed that the sensation to pin, temperature and light touch was slightly decreased in the median nerve dermatomes bilaterally, but more definitely decreased in the ulnar nerve dermatomal distributions of the fourth and fifth digits bilaterally. In his report it says that as far as the special studies it appears that the patient has findings that may indeed be compatible with both a mild bilateral carpal tunnel syndrome as well has having evidence of ulnar nerve impingement at the ulnar grooves bilaterally. It was his impression that the study should be repeated and the values of the median and sensory conduction velocities across the carpal tunnel, that is from the palms to the wrists, be obtained as well as using an inching technique when studying the ulnar nerve across the elbow. The needle EMG portion of the study would not need to be repeated since it is invariably negative. His impression was that on exam there was clinical evidence suggestive of bilateral ulnar nerve entrapment at the elbow. She has been treating conservatively with medication but had not apparently been focused on specifically in physical therapy sessions and has not improved. These will likely require surgical decompression if they are indeed confirmed electrophysiologically. She has suggestion of mild dysfunction of her bilateral median nerves, although this may not impose much of a problem symptomatologically and may respond quite well to conservative management. He did not feel she had reached MMI on that date. No impairment rating was given. He stated treatment will depend on the results of the examinee's repeat electrophysiological studies. He stated the examinee may not return to work at this time using conservative judgment, depending on the treatment.

Next is a report from the orthopedic surgeon, dated 6/27/02. This represented an IME that was performed on 6/25/02. In his report he stated she was injured on ___ while working for ___ picking up some orders and had onset of pain to both wrists. Her present complaints were that of essentially constant pain in both

forearms, right greater than left, mostly from the wrist to the elbow. She describes the pain as cramping and aching. Exam revealed range of motion of the elbows to be normal. Range of motion of the wrists was normal on exam. Deep tendon reflexes and sensation were normal. Tinel's sing caused some discomfort but was mostly local without any real radiating pain over the median and ulnar nerve areas in the wrist and cubital canal. Thus, there was no definite evidence of carpal tunnel or cubital tunnel syndrome. In his opinion a repeat EMG should be performed. He would recommend referral again to the doctor. If the EMG was still negative then he would feel that she is at MMI with a 0% impairment rating. He stated that "I feel that since this is in controversy a repeat EMG would be indicated and I would certainly recommend this be done before any surgery was performed. I do not feel the surgery should be performed in the face of a negative EMG."

Requested Service(s)

The medical necessity of outpatient services rendered from 4/15/02 through 9/17/02, including office visits and FCEs.

Decision

I agree with the insurance carrier that the above services were not medically necessary, reasonable or related to the compensable work injury.

Rationale/Basis for Decision

I do not see any reason why a repeat FCE should have been done. She had already had these done twice. The major concern at this point was as to whether or not a surgical procedure was warranted. A repeat FCE was, in my opinion, not reasonable, related or necessary.

Also, she had apparently not been responding to the physical therapy treatments and to just continue with physical therapy on a regular basis in the absence of improvement was also not reasonable.

A repeat EMG apparently was performed on 8/20/02 and subsequent to that she should have seen the hand specialist for further evaluation. If these findings were abnormal, indicating cubital tunnel syndrome, then I would agree that a surgical intervention would have likely been warranted. But to continue physical therapy in the absence of response was, in my opinion, not reasonable, related or necessary.

Therefore, the outpatient services dating from 4/15/02 to 9/15/02 were not reasonable, related or necessary as there was no significant change in the claimant's condition during that period of time from the time prior to that.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of April 2003.