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IRO NOTICE OF DECISION - WC

DATE OF REVIEW: 05-12-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of preauthorization approval for Carpal Tunnel Release, Left hand

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Certified by the Board of Orthopaedic Surgery
General Certificate in Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/Overturn
		Prospective	354.0	64721	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization denial (03-06-07 and 04-02-07)
Letters dated 05-11-07 and 05-08-07
Physician(s) evaluation and notes
Diagnostic studies (Nerve conduction study, EMG)

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant sustained an injury, while walking, slipped on mud and fell, and tried to break the fall with the left wrist and arm. Injured the entire left upper extremity and has complained of pain on the left upper extremity and shoulder as well as numbness and tingling on the fingers of the left hand. Treatment has included anti-inflammatory medications, splinting, and injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Medical necessity for the requested left Carpal Tunnel Release has been met:

1. Has failed: Splinting, medications, injection
2. Continues to have positive Tinel's & Phalen's tests
3. Continues to have symptoms of Carpal Tunnel Syndrome 6 months post injury. Night pain/tingling, weakness of pinch
4. EMG, NCV studies are not 100% accurate all the time

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**