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DATE OF REVIEW: 04.24.08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ganglion cyst removal

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery
 TX DWC ADL

REVIEW OUTCOME:

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

Overturned

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Ganglion cyst removal		-	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	UR Review		3	03.05.08	03.05.08
2	UR Review		3	03.20.08	03.20.08
3	Office Visit		8	02.12.08	03.11.08

PATIENT CLINICAL HISTORY [SUMMARY]:

Xxxx was injured on xx/xx/xx. A request has been submitted by Dr. for a resection of a wrist ganglion. The patient is xx-some years of age and was lifting a bed when he suffered an injury to the left wrist. Since that date, he has noticed a volar wrist bump diagnosed as a ganglion. Previous review suggests no imaging studies were noted and no conservative therapy was trialed. A report per Dr. notes the patient still has ongoing pain in the wrist and preservation of the mass. He further discusses the possibility of a seroma which still suggest removal of the mass as indicated despite same. He does offer further X-rays which demonstrates a soft tissue mass on the radial side of the wrist.

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

Given the time from the incident in question and the xx/xx/xx notation with continued pain and mass, I would offer that ODG does suggest this kind of surgical treatment is warranted. As referenced in a second preauthorization, this patient has failed tincture of time and a resection of the volar wrist ganglion seems appropriate.

The current online version of ODG notes: Recommended as an option when a cause of pain, interference with activity, nerve compression and/or ulceration of the mucous cysts. ([Singhal, 2005](#)) ([Nielsen, 2007](#))

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

ODG:

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), 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 .

