

# IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

**DATE OF REVIEW:** 7/24/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right Open Carpal Tunnel Release; possible Flexor Tenosynovectomy;  
Dequervain Release.

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

Board Certified in Orthopaedic Surgery  
Fellowship trained in Upper Extremities

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 6/26/08 and 7/3/08

Medical Records from Dr. 6/16/08 and 6/27/08

Medical Records from : 5/27/08 thru 7/14/08

MRI 6/12/08

Medical Record from Dr. 3/21/0-8

Medical Records from Dr. : 2/21/08 thru 4/21/08

Medical Records from 3/21/08 thru 4/25/08

Medical Record from 3/6/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured employee suffers from chronic bilateral hand and wrist pain from a repetitive work injury. She is diabetic. She has failed conservative treatment. Surgery has been denied by the insurance company.

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

The requested procedures are medically reasonable and necessary for this patient. The previous denials have been based on a strict interpretation of the ODG guidelines. They are just guidelines, not rules. The requesting and treating physician's letters of medical necessity elegantly spells out a reasonable rationale for the third injection. After reviewing the documentation, the patient has failed conservative treatment and fits the ODG criteria for the requested procedures. Rest, anti-inflammatory medications, and a home exercise program have been tried. Steroid injections are contraindicated in diabetics. The MRI should not be used to deny surgery as it is not helpful in diagnosing DeQuervain's syndrome.

**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 JUDGEMENT, 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)**