

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/06/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right carpal tunnel release, right ulnar transposition at elbow; right wrist arthroscopy triangular tibro complex cartilage.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
354.0 354.2 842.02	64721		Prosp.						Overturn

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial 3/24 & 4/17/2008, criteria used in denial (ODG).
3. Letters of appeal 3/25/08 & clinic note 4/25/08
4. Exams and follow up 1/18/08 – 3/18/08
5. Rehab notes 12/18/07 – 3/07/08
6. Neurology report 12/18/07

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient suffered an injury to the hand and wrist with triangular fibrocartilage complex tear, carpal tunnel syndrome, and ulnar nerve injury at the elbow. The patient was treated with conservative measures and elected to proceed with surgical management. Ulnar nerve transposition, carpal tunnel release, and TFCC repair have been denied as medically unnecessary by the insurance company. The patient has failed extensive conservative treatment including splinting, medications, injections and therapy.

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

This denial was based solely on the nerve conduction study. Clinically, many patients with ulnar neuropathy at the elbow have a normal nerve conduction study and even some of those with carpal tunnel syndrome. The ODG Guidelines do not properly assess these patients, and indications for surgery in this patient are correct. The clinical indications of medical necessity of these proposed surgical procedures are reasonable and indicated for this procedure.

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

- ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
- AHCPH-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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)