

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Open CTR w/1st Dorsal Compartment Release, 64721, 25000

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for Right Open CTR w/1st Dorsal Compartment Release, 64721, 25000.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/5/08
ODG Guidelines and Treatment Guidelines
Request for Preauthorization, 7/22/08
First Physicians, 9/17/07

Orthopaedic Institute, 4/4/08, 6/24/08, 7/11/08

MD, 5/5/08

DO, 8/25/08, 7/25/08, 6/16/08, 5/2/08, 4/4/08, 3/6/08, 2/12/08, 12/21/07, 11/9/07,
11/2/07, 10/18/07, 9/27/07, 9/20/07, 9/17/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female complaining of pain in the right wrist since xx/xx. She had a splint placed on her arm. She had ongoing pain in the right wrist and thumb, some numbness and tingling in the right wrist, and some night pain. She has had physical therapy and an injection, which apparently did not help. She had a carpal tunnel release on the right with improvement initially, until the fall. She has had physical examinations that have shown variance between the surgeon and the electromyographer with the surgeon finding a Tinel's sign at the right wrist and the electromyographer finding none. She is also said to have a positive Finkelstein's test by the electromyographer with no evidence of conservative treatment in the medical records. There have been noted injections into the carpal tunnel but no mention of the results of injections into the first dorsal compartment of the wrist. Current recommendation is for a repeat carpal tunnel release and first dorsal compartment release. The EMG/NCV study was negative for carpal tunnel syndrome.

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

The patient does not meet the ODG criteria for this procedure. Given the previous carpal tunnel release, the recent negative EMG/NCV study, the variance in the physical examinations, and in particular, the lack of response to carpal tunnel steroid injection (which the treating surgeon himself notes is a poor indicator of a likely successful outcome after release) this reviewer has no choice but to uphold the previous adverse determination. The reviewer finds that medical necessity does not exist for Right Open CTR w/1st Dorsal Compartment Release, 64721, 25000.

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)