

Notice of Independent Review Decision

REVIEWER'S REPORT

**DATE OF REVIEW:** 05/31/09

**IRO CASE #:**

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

Denial of tendon sheath incision for trigger finger of the patient's thumb.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery, fellowship trained hand surgeon

**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>
727.03	26055		Prosp.						Overturn

**INFORMATION PROVIDED FOR REVIEW:**

- Case assignment
- Letters of denial, 01/08 and 02/10/09, including criteria used in the denial
- MRI scan report of left elbow, 08/19/08
- Orthopedic evaluation and followup, 10/21/08 through 02/24/09, four visits

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient suffered a work-related injury to the upper extremity. This caused both elbow pain as well as stenosing tenosynovitis of the left thumb. The patient failed extensive conservative management including physical therapy, medications, and tendon sheath steroid injection. The patient is now with a fixed flexion deformity, i.e., stage III trigger digit in severe pain over the A1 pulley. Surgical release has been denied by the insurance company as medically unnecessary.

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

According to ODG Guidelines, this patient completely fits the criteria for trigger thumb release. The patient has failed conservative management including a tendon sheath steroid injection. All of these records were available for my review, and the surgery is therefore medically reasonable and necessary.

**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.
- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)