URAC ACCREDITED

CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 1-29-10
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
ASC Left Radial Tunnel Release 64708

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
American Board of Orthopaedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- Chiropractic therapy performed on 11-6-08.
- 5-19-09, DC. office visit.
- therapy on 5-27-09, 5-29-09, 6-2-09, 6-8-09, 6-10-09, 6-16-09, 6-19-09, 6-26-09, 6-30-09, 7-2-09, 7-10-09, 7-13-09, 7-17-09.
- MD., office visits on 9-17-09, 10-9-09, 11-6-09, and 12-4-09.
- 12-14-09 MD. performed a Utilization Review.
- 1-6-10 MD. performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:
Chiropractic therapy performed on 11-6-08,
5-19-09 DC. the claimant has been under care at this office for the injuries reportedly sustained while at work on xx/xx/xx. A re-evaluative examination was performed on 5-19-09 to evaluate the status of the claimant's exacerbation. The claimant reports constant

pain and weakness in the left wrist region and constant shooting pain from wrist up posterior forearm. The claimant has hypoesthesia within the C7 level on the left. DTR were hypomobile. The claimant had positive Phalens on the left, positive Cozen's on the left, positive Yergason on the left. The claimant had trigger points at the left wrist flexors and extensors. Range of motion was decreased on the left due to pain. Assessment: Wrist strain/sprain. The evaluator recommended chiropractic therapy.
Chiropractic therapy on 5-27-09, 5-29-09, 6-2-09, 6-8-09, 6-10-09, 6-16-09, 6-19-09, 6-26-09, 6-30-09, 7-2-09, 7-10-09, 7-13-09, 7-17-09.

9-17-09, MD., the claimant reports left wrist pain located at the dorsal wrist and radial wrist. The claimant has had chiropractic therapy. She also had an impairment rating on 12-3-08 and was found to have 4% impairment. The claimant was sent for a second opinion and was told she had a wrist sprain and would take time to heal. The claimant reported that the injury occurred when she had a MVA on 2-12-08 and had her hand caught within the steering wheel, it was twisted multiple times as the wheel turned violently. On exam, the claimant has tenderness at LT ligament. Sensory exam is intact. There is no atrophy. Tinel's test is negative. X-rays were normal without fracture or dislocation. Assessment: Left wrist pain likely LT sprain but not complete rupture. There is no instability. No CTS or ganglion. The evaluator recommended activity modification and wrist splint. The claimant was provided an injection to the radiocarpal joint.
Follow up with Dr. on 10-9-09 showed the claimant the injection helped her symptoms for a few days, then the symptoms returned. On exam, neurovascularly she was intact with normal light touch sensation, normal motor and normal pulse. Neurovascularly she is intact. The evaluator felt the claimant had left wrist pain with extensor muscle strain/inflammation evident. The evaluator recommended activity modification. The claimant was placed on Naprosyn and continued with the use of splint.
Follow up with Dr. on 11-6-09 notes the claimant reports she is better with occasional tingling pain in the arm. Her range of motion is good with increased strength and function. On exam, the claimant has normal range of motion. The claimant has positive resisted long finger test. There is no wrist tenderness, but there is at the radial tunnel. Radial exam showed intact sensory and motor exam. The evaluator reported the claimant's left wrist pain was resolved, but she had clear evidence of radial tunnel. The evaluator provided an injection to the radial tunnel.
Follow up with Dr. on 12-4-09 notes the claimant reported that the left radial tunnel injection did help her symptoms but wore off after 2-3 days. She feels the same as before with slightly worse pain. On exam, the claimant had positive resisted supinator test 1+, positive resisted wrist extension test 1+. The claimant had a normal neurological exam. The evaluator reported the claimant had left radial tunnel syndrome confirmed by excellent but temporary relief from injection in the radial tunnel. The evaluator saw no evidence of lateral epicondylitis. The evaluator discussed surgical intervention, which was recommended: Radial tunnel release.
12-14-09, MD., performed a Utilization Review. It was his opinion that the left radial tunnel release was not deemed medically necessary as of this time. The claimant complains of tenderness over the radial tunnel with positive provocative test, normal range of motion and intact sensation. Motors and pulse are not documented. There are no electrical studies done confirming radial nerve entrapment at the wrist. Furthermore, aside from injections, no records were provided of other conservative treatment done such as physical therapy and optimized oral medications. Additional relevant information from a peer-to-peer contact is needed to substantiate the medical necessity of this request.
1-6-10, MD., performed a Utilization Review. The evaluator reported that the request for ASC left radial tunnel release was not medically necessary at this time. The evaluator reported that there was no imaging evidence submitted for review to demonstrate the

claimant has a lesion of the radial nerve. There was no electrodiagnostic study submitted for review in addition. ODG guidelines recommend that patients be unresponsive to 3-6 months of conservative care and have positive electrodiagnostic study findings before radial tunnel release is warranted.

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

BASED ON THE MEDICAL RECORDS PROVIDED, THE CLAIMANT HAD AN INITIAL EVALUATION WITH A DIAGNOSIS OF WRIST STRAIN/SPRAIN AND NOW SHE IS BEING DIAGNOSED AS HAVING A RADIAL SYNDROME. IT DOES NOT APPEAR THAT THE CLAIMANT HAS HAD ADEQUATE CONSERVATIVE MANAGEMENT FOR THIS DIAGNOSIS. SHE HAS NOT HAD PHYSICAL THERAPY, ERGONOMIC EVALUATION, PHYSICAL THERAPY PRIOR TO EMBARKING ON SURGICAL DECOMPRESSION. ADDITIONALLY, I CANNOT RELATE THIS CONDITION WITH HER ORIGINAL INJURY. THEREFORE, THE MEDICAL NECESSITY OF THE REQUESTED ASC LEFT RADIAL TUNNEL RELEASE IS NOT REASONABLE OR MEDICALLY NECESSARY.

ODG-TWC, last update 11-6-09 Occupational Disorders of the Elbow – Radial Tunnel Release: Recommended as an option in simple cases after 3-6 months of conservative care plus positive electrodiagnostic studies and objective evidence of loss of function. Surgical decompression of radial tunnel syndrome (RTS), a relatively rare condition, remains controversial because the results are unpredictable. Surgical decompression may be beneficial for simple RTS, but may be less successful if there are coexisting additional nerve compression syndromes or lateral epicondylitis or if the patient is receiving workers' compensation. (Lee, 2007)

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)**