

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: April/4/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left wrist arthroscopy TFCC repair and Carpal tunnel release: 29846 & 64721

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

MD, Board Certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines, Forearm, Wrist, & Hand

Adverse Determination Letters, 2/25/11, 3/4/11

M.D., 5/19/10

Outpatient Imaging, 10/13/09

Orthopaedic Surgery Group 1/14/10 to 1/27/11

Medical Centers 8/17/09 to 2/4/10

Medwork Independent Review 9/1/10

EBME 6/2/10

3/18/11

PATIENT CLINICAL HISTORY SUMMARY

This patient is a male with a date of injury noted as xx/xx/xx. The patient has a TFCC tear and carpal tunnel syndrome after an acute twisting injury. According to provider's exam note dated 1/27/11, the patient has "pain over the distal radial ulnar joint. The patient has pain with radial and ulnar joint squeeze and turn test, and ulnar impingement test, localized to the ulnar head, TFCC area. Piano key sign, his wrist feels stable. Watson's maneuver negative, Reagan ballottement sign is negative. The patient has positive Phalen's and positive Tinel's over the carpal tunnel." Notes detail that the patient has failed conservative care, including bracing, NSAIDS, PT, and injections. Left wrist arthroscopy TFCC repair and Carpal tunnel release: 29846 & 64721 was denied on 2/25/11 and 3/4/11.

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

There is no documentation to suggest that the patient had any symptoms of carpal tunnel syndrome or ulnar sided wrist pain due to the TFCC tear prior to the injury. The previous denials have been based on the lack of causation and due to the lack of documented conservative care. After reviewing the medical records provided the reviewer believes these objections have been sufficiently addressed and the previous denials should be overturned. The reviewer finds there is a medical necessity for Left wrist arthroscopy TFCC repair and Carpal tunnel release: 29846 & 64721.

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

ACOEM-AMERICA 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)