

SENT VIA EMAIL OR FAX ON
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

O/P Right Carpal Tunnel Release

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

Orthopedic 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

OD Guidelines

Request for IRO dated 01/22/11

Utilization review determination dated 10/26/11

Utilization review determination dated 09/01/11

Functional capacity evaluation dated 09/29/11

Handwritten progress note dated 08/23/11

EMG/NCV study of bilateral upper extremities dated 03/11/11

Handwritten clinic note dated 04/21/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have date of injury of xx/xx/xx. The record does not contain any information regarding mechanism of injury. She was referred for EMG/NCV study on 03/31/11 which notes a mild bilateral median nerve entrapment at the wrist right

greater than left and mild right C5-6 chronic radiculopathy. Records indicate on 04/21/11 the claimant presented for right hand evaluation x 4 months. She complains of pain and numbness. She had cortisone injection into the right hand on 03/02/11. Her current medications include Naproxen and Nexium. On physical examination she is noted to have positive carpal tunnel compression test, positive Phalen's, positive Tinel's bilaterally. She was subsequently seen in follow-up on 08/23/11, and again her physical examination is unchanged. She subsequently was recommended for surgery.

The initial request was reviewed on 09/01/11 by Dr. Dr. non-certified the request noting that an abnormal Katz hand diagram, flick sign, or nocturnal symptoms are not documented in the records. There is no objective documentation that the claimant has failed conservative treatment.

A subsequent appeal request was reviewed by Dr. on 10/26/11. Dr. notes the previous non-certification based on missing criteria including abnormal Katz hand diagrams, flick sign, or nocturnal symptoms as well as objective documentation of failing conservative treatment. He noted no new additional clinical information was submitted for review, and subsequently the medical necessity of the request is not established.

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

The request for outpatient right carpal tunnel release is not supported as medically necessary, and the previous utilization review determinations are upheld. The submitted clinical records fail to provide any detailed data regarding conservative treatment to date. It would appear from the single note that the claimant received corticosteroid injection on 03/02/11. However, there is no other data regarding bracing, activity modification, occupational therapy, or other treatment options prior to request for surgical intervention. In absence of appropriate supporting documentation, the previous utilization review determinations were correct, and therefore upheld on IRO.

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)