

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 02/24/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1. Left cubital tunnel release
2. Left (CTR) carpal tunnel release

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

The TMF physician reviewer is a board certified hand surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the left cubital tunnel release and left (CTR) carpal tunnel release are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 02/08/11

- Adverse determination notification – 01/11/11, 01/26/11
- Letter from attorneys – 02/10/11
- Report of x-rays of the right hand – 05/29/09
- One page of ED record – 06/01/09
- Progress note– 12/02/08 to 04/26/10
- Clinic notes – 06/03/09 to 06/04/09
- Report of x-rays of the cervical spine – 04/09/10
- Report of chest x-ray – 02/21/10
- Referral to hand specialist – 04/26/10
- Prescription for light duty – 04/27/10
- Report of x-rays of the right hand and wrist – 05/30/10
- Peer Review Report – 05/06/10
- Office visit notes – 04/27/10 to 04/28/10
- Referral to orthopedist– 06/01/09
- Report of x-rays of the finger left hand – 09/03/09
- Letter of determination – 05/10/10, 10/26/10, 11/02/10, 11/15/10
- Orthopedic office visit notes – 10/20/10 to 01/10/11
- Request for reconsideration – 01/05/11
- Order for referral to pain management – 01/10/11
- Office visit notes – 01/04/11
- Report of EMG and NCS – 11/23/10
- Report of MRI of the right upper extremity – 10/29/10
- Report of bone scan of the wrists – 10/14/10
- Electrodiagnostic Report – 05/04/10
- Physical Therapy notes – 10/04/10 to 12/13/10
- Request for precertification – no date
- Report of designated doctor evaluation – 11/01/10
- Initial evaluation for physical therapy – 11/10/10

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury with carpal tunnel type symptoms due to repetitive type work. She complains of numbness, tingling, and burning about the left wrist. She has been treated with a splint, medications, physical therapy and injections. The treating orthopedic hand surgeon has recommended that the patient undergo left cubital tunnel release and left carpal tunnel release.

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

This injured worker is status post right carpal tunnel release that offered her no beneficial relief. She now has global left upper extremity complaints, non-anatomic and variable sensory and pain complaints, variable weakness, minimal changes on EMG and NCV and an unremarkable MRI. The patient was seen once by a surgeon who is recommending surgery without indicating the reason for the failure of the surgery performed on the right extremity and without an adequate trial of conservative treatment. Prior injections were without benefit and would thus argue against the diagnosis of carpal tunnel syndrome and would also hold for the failed response to the right carpal tunnel release. The patient's history and physical is most consistent with musculoskeletal complaints and potential overwork that would not show improvement with surgery which has already been demonstrated on the right extremity.

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)