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Notice of Independent Review Decision

DATE OF REVIEW: 7-12-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of ASC left dorsal wrist excision soft tissue mass (25076).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the ASC left dorsal wrist excision soft tissue mass (25076).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Recent attending physician records were reviewed, including the surgical date, pre- and post-op notes were also reviewed. The claimant was noted to be status-post dorsal mass excision/tenosynovectomy on 10/26/00, status post a date of injury of xx/xx/xx. The claimant was noted (on 4/21/11) to have a painful tender palpable (2x3 cm.) dorsal wrist mass. Despite the prior excision, the patient reported that the mass had been present intermittently, has become larger and is causing painful wrist dysfunction. The mass had flattened out, as reported on 6/19/11. Splinting and possible aspiration were felt indicated in the future, as was further follow-up. Prior determinations were noted.

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

With the mass having flattened to a smaller size, inconsistent pain and lack of ongoing functionality interference, and lack of nerve compression or ulceration; there is no indication for such a proposed procedure. In addition, without a comprehensive trial and failure of non-operative methods; there is no ODG guideline-associated rationale for mass excision as proposed. Reference: ODG-Wrist/Hand/Forearm Chapter; Surgery for ganglion cysts Recommended as an option when a cause of pain, interference with activity, nerve compression and/or ulceration of the mucous cysts. (Singhal, 2005) (Nielsen, 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)**