

SENT VIA EMAIL OR FAX ON
Nov/03/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Nerve Compression LT Elbow with Left DeQuervains Tenosynovitis LT ECT Release

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

General 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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is Xx/xx/xx. He reportedly fell at work. He complains of left hand pain. The claimant was noted to have pain, numbness and tingling to left hand. There was noticeable weak grip and positive Finkelstein's test. Electrodiagnostic testing was performed on 08/11/11 and revealed evidence of ulnar nerve compression at the level of left elbow (cubital tunnel syndrome). There was moderate left and mild right carpal tunnel syndrome, with no evidence of cervical radiculopathy or brachial plexopathy. According to Dr. letter dated 09/14/11, the claimant presented with left hand pain, numbness and tingling. He was also noted to have pain over the radial styloid, weak grip, and double positive Finkelstein's test. EMG/NCV studies on 08/11/11 were positive for left sided carpal tunnel syndrome and ulnar neuropathy at the elbow. Dr. noted the claimant has failed

physical therapy and injections. He is not improving and needs surgical treatment.

A utilization review performed on 08/30/11 determined the request for nerve compression of left elbow with left de Quervain's tenosynovitis left ECT release was non-certified as medically necessary. It is noted that medical report dated 08/09/11 indicated the claimant has left upper extremity pain. He was noted to have severe de Quervain's. It was noted that a more detailed and comprehensive subjective and objective clinical evaluation was not provided for review. Radiologist analysis reported the x-ray and documented analysis of EMG/NCV were not submitted for review. It was further noted that the medical report failed to objectively document exhaustion of conservative treatment such as activity modification, home exercise program, oral pharmacotherapy, corticosteroid injections, night splints and physical therapy. There were no VAS pain scales, procedure reports of injections, or physical therapy notes documenting lack of progress. There was no objective evidence the claimant was unlikely to gain clinically significant functional response from continued treatment from less invasive modalities. Maximum potential of conservative treatment was not fully exhausted to indicate surgical procedure.

A review performed on 10/03/11 determined that reconsideration request / appeal nerve compression left elbow with left de Quervain's tenosynovitis left ECT release was non-certified as medically necessary. It was noted the claimant had electrodiagnostic studies indicative of ulnar nerve compression at level of left elbow, indicative of cubital tunnel syndrome and moderate left and mild right carpal tunnel syndrome. The claimant was noted to have had physical therapy and injections, but physical therapy notes were not submitted for review, and injections have not been described as to whether they were for carpal tunnel or for cubital tunnel. There is no indication of the number of injections provided. Official Disability Guidelines, Indications for Surgery for Cubital Tunnel Syndrome indicate conservative treatment requiring exercise, activity modification, medications, and pads or splints should be tried before surgery. Conservative treatment plan for 6 weeks should be tried before the claimant is sent for surgery. Recommendations for de Quervain's tenosynovitis surgery indicate surgery was alternative with consistent symptoms, signs, and failed 3 months of conservative treatment with splinting and injections. Carpal tunnel surgery is recommended if muscle atrophy is noted. Severe weakness of thenar muscles is noted and positive Tinel's and Phalen's sign. A period of activity modification, splinting, and non-prescription analgesics must be tried before the claimant is sent to surgery for carpal tunnel syndrome. Therefore, the proposed surgical procedure is not considered medically necessary as the claimant has failed to demonstrate exhaustion of conservative treatment.

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

Based on the clinical information provided, the request for nerve compression left elbow with left de Quervain's tenosynovitis left ECT release is not indicated as medically necessary. Records indicate the claimant sustained an injury to left upper extremity secondary to fall at work. He has objective findings on electrodiagnostic studies consistent with left cubital tunnel syndrome with moderate left and mild right carpal tunnel syndrome. Clinically the claimant was found to have significant de Quervain's tenosynovitis. The claimant is reported to have had injections and physical therapy. According to reevaluation report dated 07/08/11, the claimant had completed 11 visits of therapy since initial evaluation on 06/10/11. It is noted the claimant was placed in thumb spica splint which provided significant relief while wearing this splint, but there is severe pain with any gripping or twisting activities. The claimant was also taken off work. Although the claimant reportedly has failed injections, there is no indication if injections were performed at left wrist and / or left elbow. Given the current clinical data, medical necessity is not established for surgical intervention and previous denials should be 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)