



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

Date: November 18, 2011

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 11/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the brown endo bilateral carpal tunnel release, right side 1st, then left side, 29848, 25020 medically necessary for this patient?

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

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Assignment to 11/08/2011
2. Notice of assignment to URA 11/07/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 11/07/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/07/2011
6. Letter from Insurance 10/07/2011, Letter from Orthopedics 09/30/2011, Letter from Insurance 09/12/2011, Worker Injury Verification 09/12/2011, Progress Notes 08/29/2011, Preliminary Reports 08/29/2011, Medicals 08/29/2011, 08/04/2011, Notice of Referral 05/02/2011, Medicals 04/14/2011, 03/08/2011,
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY

The patient is a female. In looking at the medical records, it is evident that the patient has carpal tunnel syndrome, by nerve conduction studies and physical exam. The medical records, however, do not document adequately conservative treatment. There is no indication of



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medication or splinting that has been tried for this problem. There is no indication of any physical therapy, home training, or injection treatment.

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

There has not been recent documentation of any conservative treatment documented, therefore, the request remains upheld.

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

ODG GUIDELINES MUST BE USED IN DECISION = PER TX RULE

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)