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Notice of Independent Review Decision
Amended and Sent on 5/28/2012

DATE OF REVIEW: 5/16/2012

DATE OF AMENDED DECISION: 5/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient release of first dorsal compartment of the left wrist.

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

M.D. Board Certified in Plastic Surgery and Hand 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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	4/26/2012
Notice of Utilization Review Findings	4/17/2012-4/25/2012
M.D. Request for Review by an IRO	4/21/2012
Progress note	3/21/2012
Request for Insurance Coverage	3/26/2012



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PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a man who suffered a left wrist injury while performing his normal work duties. Mechanism of injury is not documented. The injured worker noted a gradual onset of left wrist pain. MRI of the left wrist noted as consistent with possible Scapholunate dislocation, and possible TFCC tear. Job modification was recommended and a Kenalog injection given, with temporary relief.

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

According to Dr. note dated 3/21/2012, the patient's complaints pertain to the radial side of the left wrist; he complains of pain when gripping objects tightly with his thumb. The pain wakes him up at night; sometimes the pain "shoots-up" his forearm. He doesn't describe any numbness or tingling in the fingers. MRI revealed a possible chronic S-L dislocation and possible tear of the triangular fibrocartilage complex (TFCC). Treatment included physical therapy and injection. Per Official Disability Guidelines, Forearm, Wrist, & Hand chapter, criteria for first dorsal compartment release are not met. Sufficient conservative treatment including splinting and work evaluation is not documented. The request for outpatient release of first dorsal compartment of the left wrist is not medically necessary.

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)



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OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES.