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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/18/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right radial tunnel release

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

General Surgery

Fellowship: Orthopedic Hand and Upper Extremity 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:

ODG - Official Disability Guidelines & Treatment Guidelines

Electrodiagnostic studies dated 08/13/12

Electrodiagnostic studies dated 08/01/13

Clinical note dated 09/09/13

Adverse determinations dated 09/23/13 & 10/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a gradual onset of hand pain. The EMG report dated 08/01/13 revealed low amplitude at the left ulnar sensory nerve action potential. An absent right radial sensory nerve action potential was also noted. These findings were noted to indicate a right radial nerve entrapment at the forearm. The clinical note dated 09/09/13 indicates the patient having a 2 year long history of persistent hand pain on the right. The patient stated that she was experiencing numbness and tingling which is exacerbated when she picks up her grandson. The patient also noted night pain that was affecting her sleep. The patient was subsequently diagnosed with cubital tunnel syndrome as well as radial tunnel syndrome confirmed by the EMG. The patient was noted to continue with work at a very limited duty. The patient stated her symptoms were aggravated by her work. No strength deficits were noted throughout the upper extremities. Reflexes were noted to be 2+ throughout. The patient was able to demonstrate normal range of motion at the right elbow. Tenderness was noted over the radial nerve. This was noted to be increased with resisted wrist and long finger extension. Diminished sensation was noted on the right at the ring and small fingers. A positive Tinel's sign was noted. The note indicates the patient having extensive conservative therapies over the previous year and a half. A radial tunnel release was recommended.

The prior utilization review dated 09/23/13 resulted in a denial for a radial tunnel release as no evidence confirming a loss of function was noted.

The utilization review dated 10/02/13 resulted in a denial as no information was submitted regarding the patient's completion of a full course of conservative therapy.

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

The patient is noted to have complaints of right upper extremity pain. A radial tunnel release is indicated after 3-6 months of conservative care plus positive electrodiagnostic studies and objective evidence of loss of function. No information was submitted confirming the patient's objective loss of function. There is mention in the clinical notes regarding significant completion of conservative treatments. However, no dates or the number of sessions of conservative therapy were submitted specifically focusing on the right upper extremity complaints. As such, it is the opinion of this reviewer that the request for a right radial tunnel release is not recommended as medically necessary.

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)