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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left wrist carpal tunnel release

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for a left wrist carpal tunnel release is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left hand on xx/xx/xx. The clinical note dated 04/01/14 indicates the patient complaining of pain and swelling at the left hand along with persistent numbness and weakness. The patient was being recommended for electrodiagnostic studies as well as an MRI of the left wrist and hand. X-rays completed at this office visit revealed no obvious fractures or dislocations. The electrodiagnostic studies completed on 05/07/14 revealed evidence of a median neuropathy at the left wrist consistent with carpal tunnel syndrome. The therapy note dated 05/29/14 indicates the patient having initiated physical therapy at that time. The clinical note dated 08/04/14 indicates the patient utilizing Ibuprofen for ongoing pain relief. The patient continued to rate the left hand and wrist pain as 7-8/10. Upon exam, the patient was able to demonstrate 45 degrees of left wrist flexion, 25 degrees of extension, and 15 degrees of both radial and ulnar deviation. The note indicates the patient having positive findings consistent with Phalen's and Tinel's. Decreased sensation was identified in the median and ulnar distributions. The clinical note dated 08/19/14 indicates the patient continuing with left wrist pain. The patient was being recommended for a carpal tunnel release at that time.

The utilization reviews dated 08/12/14 & 09/12/14 resulted in denials as insufficient information had been submitted regarding the patient's provocative findings identified by clinical exam and insufficient information had been submitted regarding the patient's completion of all conservative treatments.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of left wrist and hand pain with associated numbness and tingling. A carpal tunnel release is indicated provided the patient meets specific criteria to include the completion of all conservative treatments and provocative findings indicate the likely benefit of the proposed surgical procedure. There is an indication the patient has initiated therapy; however, no information was submitted regarding the patient's completion of all conservative treatments to include therapeutic interventions. Additionally, no information was submitted regarding the patient's Katz diagram or a positive Flick's sign. Given these factors, the request is not fully indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a left wrist carpal tunnel release is not recommended as medically necessary and the prior denials are upheld.

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 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)