INDEPENDENT REVIEW INCORPORATED

DATE: 09.22.14

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 9.22.14

IRO CASE #:

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

M.D., Board Certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

De Quervain's release

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

_____ Upheld (Agree)

__X__ Overturned (Disagree)

_____ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
727.04	*25000*		*Prosp.*				*Xx/xx/xx*		*Overturned*

PATIENT CLINICAL HISTORY (SUMMARY):
The claimant is a male who presented on 03/24/14 with bilateral radial-sided wrist pain and a diagnosis of De Quervain's tenosynovitis. The claimant had been treated with conservative care including anti-inflammatory medications, ten physical therapy sessions, bracing, and a steroid injection with minimal relief. Surgery had been recommended but denied. The claimant was then referred a chiropractor for ongoing treatment. tried initial conservative management with splinting, anti-inflammatories, and activity modification. However, since he did not improve, hand surgery was recommended; this was denied twice. I reviewed the denials and it appears that the denial was based on the lack of objective documentation of three months of conservative care, as well as the lack of an ability to discuss the case.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the review of the records, this claimant has had an extensive amount of conservative care, some of which was provided to the claimant outside r. He has had adequate conservative care and because of the lack of improvement with conservative care, as well as steroid injections, and documented inflammation of the first and fifth compartments on MRI, I believe that surgical treatment is medically reasonable and necessary and clearly conforms to the Official Disability Guidelines as this claimant is a surgical candidate and would benefit from a surgical release. I, therefore, overturn the denial and believe that surgery is indicated for this claimant.

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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 judgment, clinical experience and expertise in accordance with accepted medical Standards
_____Mercy Center Consensus Conference Guidelines
_____Milliman Care Guidelines
_X___ODG-Office 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)

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