

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 12/14/12

IRO CASE #:

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

Texas-licensed Doctor of Medicine (M.D.), Board Certified in Orthopaedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left pin decompression and proximal forearm and left decompression radial nerve.

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
354.3	64708		Concurrent		11/01/12 - 11/13/12				

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letter of denial 11/01/12 & 11/13/12, including criteria used in the denial, and correspondence dated 11/27/12.
3. Medical timeline provided by Carrier.
4. TDI Order 07/2011.
5. Orthopedic peer review 03/08/12.
6. Orthopedic clinic notes 08/11/11 through 09/27/12.
7. Designated Medical Examination 11/10/11.
8. Electrodiagnostic study of left hand 10/25/11.
9. Orthopedic retrospective review 03/31/11.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient suffered a traumatic injury to the left elbow with a forced hyperextension type injury that led her to develop pain in the proximal forearm that was incorrectly initially diagnosed as lateral epicondylitis. The patient has been treated by a fellowship-trained hand surgeon and worked up for radial nerve compression. The patient's symptoms are that of radial nerve compression in the proximal forearm and at the wrist. The patient has exhausted extensive conservative care. The insurance company has denied decompression of the radial nerve because of multiple issues that they feel would interfere with the success of the surgery. They state that electrodiagnostic testing is negative. They state that the patient has psychological issues that would preclude surgery.

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

Request for radial nerve decompression is medically reasonable and necessary. Based on the clinical examination, diagnostic workup including a diagnostic injection, and the failure of adequate conservative care, the request for radial nerve decompression both in the forearm and at the wrist is medically reasonable and necessary and should be approved. The criteria used in the multiple insurance company denials are not based upon sound hand surgery principles.

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
- 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):
Green's Operative Hand Surgery, 5th Edition
- Other evidence-based, scientifically valid, outcome-focused guidelines (Provide a Description)