CASEREVIEW

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March 14, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient surgery for repair of XX XX with debridement, open, revise XX nerve at XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 18 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX year old XX who was injured on XX when XX had a XX XX XX after XX on XX XX on the XX while XX XX XX in the XX. XX hit XX XX and XX XX, in the XX area, and also had a sprained XX/XX XX. XX XX MRI performed on XX revealed XX, possible contusion in the soft tissues overlying the XX tunnel and the XX, likely causing irritation of the XX nerve which has slightly high XX signal, and was minimally enlarged at the XX tunnel. EMB/NCS performed on XX revealed no median neuropathy at the L writs, no XX XX neuropathy, no generalized XX neuropathy, no XX XX-XX radiculopathy, and no significant electrodiagnostic abnormalities. There were no tears or fractures seen. Treatment has included XX therapy, NSAIDs, activity modification, XX, and corticosteroid injection.

On XX, the claimant presented to XX with continued pain in XX XX XX with numbness into XX small XX XX. Diagnosis: XX tunnel syndrome, medical XX, and lateral XX. On examination XX had tenderness on the lateral and medial XX and XX tunnel. Pain with resisted wrist extension and flexion. Normal strength. Sensation intact to light touch. Positive Tinel's and flexion/compression test. Plan: After failing extensive nonoperative management for approximately XX months, the patient would like to proceed with surgery at this point. XX is unable to lift, push or pull much with XX XX XX extremity. Surgery consists of XX lateral and medial XX debridement and repair, as well as XX XX at the XX.

On XX, the claimant presented to XX after surgery was denied. XX had to go to the ER for XX XX pain and was given muscle relaxants that seemed to help slightly. XX and XX did not help. Plan: XX was given a XX XX as well as XX to take. XX will perform home therapy. XX may return to work with no lifting, pushing, or pulling. Request repeat XX XX extremity EMG and NCS if continued pain.

On XX, the claimant presented to XX with continued significant pain, dysfunction, and numbness. Plan: XX was given a prescription for XX to try to help with XX. XX may continue with XX XX tunnel XX and may return to work with no lifting, pushing, or pulling. XX had a previous EMG and NCV that was negative. However, XX has very obvious, clinical XX tunnel and will request a XX XX extremity EMG/NCV.

On XX, the claimant presented to XX who recommended proceeding with surgery consisting of XX lateral and medial XX debridements and XX XX at the XX.

On XX, XX performed a UR. Rationale for Denial: The ODG supports surgery for XX when there have been persistent symptoms that have failed to improve with XX of nonoperative management including NSAIDs, banding, activity modification, and XX therapy. The documentation provided indicates that the injured worker has continued complaints of XX XX pain that have failed to improve despite therapy, bracing, NSAIDs, and corticosteroid injection. The provider documents a physical exam of tenderness over the XX medical and lateral XX and pain with resisted wrist extension and flexion as well as lifting and pronation and supination. The provider indicates a diagnosis of medial and lateral XX and is recommended d a XX XX medial and lateral XX debridement. Based upon the documentation provided, the ODG would not support the request medial and lateral XX XX debridement as there has not been XX months of nonoperative management. However, the patient has had XX months of nonoperative management and conservative measures have been exhausted. It is unlikely that the injured worker will improve with continued conservative care over the next XX months. Therefore, the requested XX medial and lateral XX debridement are recommended for certification. However, I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time.

The ODG supports surgical intervention for XX tunnel syndrome in the form of decompression for XX tunnel syndrome that has failed to improve with at least XX months of conservative care. Criteria include XX months of activity modification, NSAIDs, night XX, and XX therapy. There should be documented pain, functional difficulty, and sensory deficit involving the small and XX. A physical examination should document a positive Tinel's or positive XX flexion test, and there should be abnormalities on a nerve conduction study consistent with XX neuropathy at the XX. The documentations provided indicates that the injured worker has a continued complaint of XX XX pain that is not improved despite therapy, bracing, NSAIDs, and corticosteroid injection. A physical examination of the XX XX documented a positive Tinel's and flexion compression test. The provider indicated that electrodiagnostic testing was negative for XX tunnel syndrome. There is no documentation of a complaint sensory deficit in the small and XX XX. The provider is indicated a diagnosis of XX XX tunnel syndrome and is recommended XX XX. Base upon the documentation provided, the ODG would not support the requested surgical intervention for XX tunnel syndrome as there is no documentation of complaints of sensory deficit in a small and XX XX and no documentation on electrodiagnostic testing of XX tunnel syndrome. As such, the request is recommended for noncertification.

On XX, XX, XX performed a UR. Rationale for Denial: The ODG supports surgery for XX when there have been persistent symptoms that have failed to improve with XX of nonoperative management including NSAIDs, XX, XX modification, and XX therapy. The documentation provided indicates that the injured worker has continued complaints of XX XX pain that have failed to improve despite therapy, XX, NSAIDs, and corticosteroid injection. The provider documents a physical exam of tenderness over the XX medical and lateral XX and pain with resisted XX extension and flexion as well as lifting and pronation and supination. The provider indicates a diagnosis of medial and lateral XX and is recommended d a XX XX medial and lateral XX debridement. Based upon the documentation provided, the ODG would not support the request medial and lateral XX XX debridement as there has not been XX XX of nonoperative management. However, the patient has had XX of nonoperative management and conservative measures have been exhausted. It is unlikely that the injured worker will improve

with continued conservative care over the next XX. Therefore, the requested XX medial and lateral XX debridement are recommended for certification. However, I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time.

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

The request for XX XX debridement of the lateral and medial XX, and XX XX is not found to be medically necessary at this time.

The claimant is a XX-year old XX who took a XX on XX, injuring XX XX XX. The XX XX MRI demonstrated a contusion in the region of the XX nerve in the XX tunnel. The XX EMG/NCS confirmed no evidence of radiculopathy or XX tunnel syndrome.

XX continues to have XX pain despite a course of therapy, bracing, NSAIDs, and corticosteroid injections. On examination, the patient is tender along the XX tunnel, medial and lateral XX. XX has XX pain with resisted flexion and extension of the XX. XX has a positive Tinel's over the XX tunnel. XX has intact sensation in the little and XX. The treating provider has recommended surgical intervention for the medial and lateral XX as well as for the XX tunnel syndrome.

The Official Disability Guidelines (ODG) supports surgery for lateral and medial XX following XX of conservative care. The ODG recommends surgery for XX tunnel syndrome in patients who have failed XX of conservative care with subjective and objective clinical findings consistent with imaging findings. Subjective findings include pain, functional difficulty and sensory deficits in the XX and XX.

This claimant does not have sensory deficits in the XX and XX. XX electrodiagnostic testing confirms no evidence of XX nerve compression at the XX. XX does not require surgery for XX tunnel syndrome.

It is unusual for a patient to have both medial and lateral XX following a XX energy XX. Based on the records reviewed, there is no evidence of tendinopathy on MRI, associated with medial or lateral XX. The claimant has received cortisone injections in the past. Documentation of the claimant's response to cortisone injections for both medial and lateral XX is required prior to surgical consideration.

The patient is not a surgical candidate.

PER ODG: XX

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)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**