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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left wrist diaphyseal shortening (CPT code 25390), outpatient surgery

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of Left wrist diaphyseal shortening (CPT code 25390), outpatient surgery.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office notes (07/10/07 – 11/19/07)
- Operative notes (07/06/07)

Texas Department of Insurance:

- Utilization reviews (12/03/07 – 12/19/07)

Reference source cited in the treatment denials: Online , M.D.); AAOS, Orthopedic Knowledge Update 8, Vaccaro, editor, Chapter 29, page 332 to 333; stated ODG Guides does not address

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old patient who injured his left hand on xx/xx/xx. On July 6, 2007, M.D., performed a left wrist arthroscopic triangular fibrocartilage repair for the diagnosis of triangular fibrocartilage tear. Dr. prescribed Darvocet N-100 for postoperative pain control. In October, the patient stated his pain was the same as prior to the surgery. The left wrist function was the same compared to the

contralateral side but the small finger had incomplete terminal hyperextension at the metacarpophalangeal joint and the fovea and the triangular fibrocartilage were very tender. Dr. continued nonsteroidal anti-inflammatory drugs. He suspected some scar around the extensor digiti minimi and demonstrated exercises for that. On November 19, 2007, Dr. noted complaints of continued pain. Tight fist views of the left hand showed slight distal radioulnar joint widening and 1+ ulnar variance. Pain was very focal at the triangular fibrocartilage. Dr. felt that the surgery did not relieve the patient's symptoms and he was in need of ulnar diaphyseal shortening.

On December 3, 2007, Dr. request for left wrist diaphyseal shortening was denied. The rationale provided stated: *Records do not reflect enough information to support the request for the surgical procedure. Records do not reflect lower levels of care have been exhausted. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines... the request is not indicated.*

On December 19, 2007, the appeal was denied. It explained: *...one plus ulnar variance is certainly not uncommon and in and of itself would not be a surgical indication. It would be necessary to confirm the failure of thorough conservative care prior to authorization of another operative procedure in this young patient's wrist.*

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

MR. HAS UNDERGONE CONSERVATIVE TREATMENT AS WELL AS ARTHROSCOPIC TFCC REPAIR FOR TFCC TEAR IN THE SETTING OF AN ULNAR POSITIVE WRIST. FAILURE OF THIS TREATMENT IS CLEARLY AN INDICATION FOR ULNAR SHORTENING OSTEOTOMY. THE CITATION CITED FROM WHEELLESS TEXTBOOK OF ORTHOPAEDICS BY TRUMBLE, ET. AL. IN THE JOURNAL OF HAND SURGERY, VOLUME 22(5), 807-13, 1997 ACTUALLY SUPPORTS THE USE OF ULNAR SHORTENING OSTEOTOMY IN THIS SETTING AND DESCRIBES THE GOOD RESULTS ACHIEVED. ULNA POSITIVE WRISTS HAVE BEEN SHOWN TO HAVE AN INCREASED RISK FOR TFCC TEARS AND CORRECTION OF THIS DEFORMITY HAS BEEN SHOWN, BY MULTIPLE AUTHORS, TO HAVE A BENEFICIAL IMPACT ON THE PATIENT. MR. HAS EVERY INDICATION FOR ULNAR SHORTENING OSTEOTOMY AND THE PROCEDURE IS CERTAINLY JUSTIFIED.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG GUIDES DO NOT ADDRESS

- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

Ulnar shortening for triangular fibrocartilage complex tears associated with ulnar positive variance.

[Minami A, Kato H.](#)

Department of Orthopedic Surgery, Hokkaido University School of Medicine, Sapporo, Japan.

Twenty-five patients with triangular fibrocartilage complex (TFCC) tears associated with ulnar positive variance who did not respond to conservative management were treated by ulnar shortening. The follow-up period averaged 35 months. All patients complained of pain, restricted forearm rotation, and weakness of grip. Arthroscopy was performed in 23 of 25 wrists to assess the status of the TFCC and the degree of the degenerative change of the proximal aspect of the lunate and triquetrum. Arthroscopic findings consisted of 15 class 1 and 8 class 2 tears according to Palmer's classification. When the TFCC showed a traumatic flap tear, only the torn flap was removed arthroscopically. Ulnar shortening averaged 3 mm. Transverse osteotomies healed in all patients at a mean postoperative time of 7 weeks. Twenty-three patients had either complete relief or occasional mild pain of the wrist. Two patients with persistent pain had additional procedures performed. Postoperative x-ray films revealed slight degenerative changes at the distal radioulnar joint in 7 patients. Complications included 1 reflex sympathetic dystrophy and 2 fractures through the osteotomy site after early plate removal. **Ulnar shortening is a useful procedure for TFCC tears associated with ulnar positive variance.**

[J Hand Surg \[Am\]. 1997 Jul;22\(4\):694-8.](#)

Ulna-shortening osteotomy after failed arthroscopic debridement of the triangular fibrocartilage complex.

[Hulsizer D, Weiss AP, Akelman E.](#)

Department of Orthopaedic Surgery, Brown University School of Medicine, Rhode Island Hospital, Providence, USA.

Over a 4-year period, 160 wrist arthroscopies were performed at 1 institution. Ninety-seven patients had central or nondetached ulnar peripheral tears of the triangular fibrocartilage complex (TFCC). All these patients underwent debridement with an arthroscopic shaver. Thirteen of the 97 had persistent pain in the TFCC region for more than 3 months after surgery. At an average of 8 months after failed arthroscopic debridement of the TFCC, all 13 patients underwent a 2-mm-long ulna-shortening osteotomy with fixation by a 3.5-mm 6-hole dynamic compression plate. At follow-up examination (an average of 2.3 years later), 12 of the 13 had complete relief of pain at the ulnar side of the wrist. One patient continued to complain of pain with moderate to heavy activity use of her hand. Four of the 13 had postoperative complications: 1 had traumatic pull-out of the screws requiring reinsertion and distal radius bone graft, 1 had nonunion at 4 months after surgery that required iliac crest bone graft, and 2 had pain necessitating hardware removal. All 4 of these patients had no further problems at

final follow-up evaluation. There was no statistically significant difference between the arthroscopic debridement alone cohort and the arthroscopy/ulna-shortening subgroup relative to ulnar variance or incidence of associated lunotriquetral ligament tears. On the basis of these findings the authors recommend a 2-mm-long ulna-shortening osteotomy for patients whose previous arthroscopic debridement for central or nondetached peripheral TFCC was unsuccessful in eliminating ulnar-sided wrist pain.

[J Hand Surg \[Am\]](#). 2001 Nov;26(6):1047-52.

Combined arthroscopic TFCC debridement and wafer resection of the distal ulna in wrists with triangular fibrocartilage complex tears and positive ulnar variance.

[Tomaino MM](#), [Weiser RW](#).

Department of Orthopaedic Surgery, University of Pittsburgh Medical Center, Pittsburgh, PA, USA.

Because a certain percentage of patients with positive ulnar variance experience incomplete pain relief after triangular fibrocartilage complex (TFCC) debridement alone, we prospectively evaluated the feasibility and efficacy of combining arthroscopic TFCC debridement with arthroscopic wafer resection in such wrists as part of the same surgical procedure. We enrolled 12 patients between July 1998 and July 2000 and performed both subjective and objective assessment at follow-up with a minimum of 6 months and an average of 14 months. Seven posttraumatic and 5 degenerative tears were identified. Preoperative ulnar variance with a pronated grip x-ray averaged 2 mm and ranged between 1 and 4 mm. At final review 8 patients experienced complete pain relief and 4 experienced only minimal symptoms. The ulnocarpal stress test failed to elicit pain in any wrist. Nine patients were very satisfied, and 3 were satisfied. Grip strength improved 8 kg (36%). This procedure should be considered in the treatment of ulnar wrist pain when TFCC tears and positive ulnar variance coexist.

[Unfallchirurg](#). 2000 Mar;103(3):197-202.

Indication and results of ulna shortening osteotomy in ulnocarpal wrist joint pain

[Article in German]

[Tränkle M](#), [van Schoonhoven J](#), [Krimmer H](#), [Lanz U](#).

Klinik für Handchirurgie (Abteilung I), Bad Neustadt/Saale.

The ulnar impaction syndrome is proven to be a common source of ulnar sided wrist pain. Ulna-shortening osteotomy represents a successful therapy for this kind of problem, both congenital or posttraumatic positive ulnar variance. Positive variance resulting from a distal radius fracture needs correct dorsal and radial angulation of the radius. In case of congenital positive variance arthroscopic

debridement for decompression of the TFCC should be performed first. The adequate correction of the length is the major problem. Disorders of the distal radioulnar joint may result due to overcorrection. Oblique osteotomy using 7-hole-plates is our preferred treatment.