



## Medwork Independent Review

1217 Menomonie Street  
Eau Claire, Wisconsin 54703  
1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW: 03/17/2008**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Rt wrist fusion 01/31/2008

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

Texas State Licensed MD Board Certified Orthopaedic Surgeon

**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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to Medwork 02/27/2008
2. Notice to URA of assignment of IRO dated 02/27/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 02/26/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 02/18/2008
6. letter Post Appeal Review 02/22/2008
7. letter Peer Reviewer Triggered 01/21/2008
8. Appeal letter 02/22/2008
9. Pre-Authorization letter 01/20/2008
10. Office notes 01/09/2008; 12/11/2007(OP report); 11/14/2007; 09/10/2007; 8/29/2007 (EMG); 08/08/2007; 07/17/2007 (OP report); 06/27/2007; 04/26/2007 (OP report); 04/18/2007; 04/13/2007 (MRI); 04/11/2007; ECG 04/25/2007; Xray (fluoroscopy) & order 03/27/2007; office note 03/23/2007; Medical & Surgical Assoc. face sheet 03/26/2007; Regional Health System Instructions following ER care 03/19/2007
11. ODG guidelines were not provided by the URA



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### **PATIENT CLINICAL HISTORY:**

This patient sustained an injury. He was subsequently assessed as having an injury to the navicular. I should note that an MR scan was carried out on April 13, 2007. A radial styloid fracture was identified. The navicular did not appear frankly fracture. There was an increase in the scapholunate interval indicating a scapholunate ligament tear.

The patient was reassessed by the physician noted to have a DISI instability pattern. Surgery was undertaken on May 26, 2007. Hardware was subsequently removed on July 17, 2007. I have reviewed the office note of November 14, 2007. At that time, it was recommended that the patient have carpal tunnel surgery and a right wrist fusion. I should note that any fractures had been noted to have healed. Carpal tunnel surgery was undertaken on December 4, 2007. I have noted the follow-up note of January 9, 2008. There is no mention in that note of any necessity for further surgery.

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

In my opinion, the previous adverse determination should be upheld. In my opinion, there is absolutely no indication for the necessity of a carpal fusion.

I have relied on the ODG Guidelines. I have relied on the medical judgment, clinical experience and expertise in accordance with accepted medical standards.

This man had a scapholunate injury. He had surgery for this. All fractures have healed. He has had carpal tunnel surgery which appears to have been successful.

There is no indication as to the necessity for a carpal fusion.

### **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



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- 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)**