

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/01/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Right Proximal Row Carpectomy vs. Scaphoid Excision and Four Corner Fusion and Right Wrist Denervation; 1 purchase of pain pump; 7 days post-op cryotherapy Rental

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

M.D., board certified in Orthopedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 9/9/09, 8/20/09, 9/8/09

MD, 10/17/08, 10/30/08, 11/11/08, 4/23/09, 8/3/09, 8/13/09, 9/22/09

Right Wrist MRI, 10/21/08

CT of the Right Wrist, 8/11/09

Reconsideration Request, 8/13/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who, according to the records, was injured on xx/xx/xx when he fell backwards from a ladder. He was stated to have a traumatic arthropathy of the thumb unresponsive to steroid injections, an ulnar collateral ligament injury. CT scan and MRI scan of the wrist demonstrated some mild arthritic changes, scapholunate ligament injury with possible dorsal articular segmental instability noted. There is note of normal grip strength, some swelling, and some pain. There are multiple areas that appear to be symptomatic based upon the treatment given. The request is for either a proximal row carpectomy or a scaphoid excision and four-corner fusion of the right wrist with denervation. The reason for two different procedures has not been given.

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

Based upon the Official Disability Guidelines and Treatment Guidelines, the use of a wrist

fusion is generally considered in a young patient requiring heavy use of the wrist and hand. This is also modified by the requirement that it is a joint that has fixed painful deformity, instability, loss of motion, or salvage of a failed implant arthroplasty. These conditions do not appear to be met in this particular instance. Given the patient's age, his normal grip strength, and the mild arthritic changes, notwithstanding the findings of possible dorsal articulated instability, the requesting physician has not explained why the ODG Guidelines should be set aside in this particular instance. It is for this reason that the adverse determination could not be overturned. In the absence of a surgical procedure, the postoperative cryotherapy and pain pump would also not be medically necessary. The reviewer finds that medical necessity does not exist at this time for 1 Right Proximal Row Carpectomy vs. Scaphoid Excision and Four Corner Fusion and Right Wrist Denervation; 1 purchase of pain pump; 7 days post-op cryotherapy Rental.

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

ACOEM-AMERICA 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)