



## REVIEWER'S REPORT

**DATE OF REVIEW:** 04/02/09

**IRO CASE #:**

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

Removal of hardware and open reduction internal fixation of distal radius fracture with allograft or autograft, left wrist, with open reduction of scaphoid fracture versus excision, repair triangular fibrocartilage complex, and carpal tunnel release

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering complex wrist and hand injuries

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. ZRC forms
2. TDI referral forms
3. Denial letters from 01/28/09 and 02/17/09
4. URA records
5. medical record review, 01/28/09 and 02/17/09
6. Fax cover sheet
7. EPOG, fax cover, 01/23/09
8. EPOG clinical notes, 01/08/09, 12/11/08, 11/06/08, 11/05/08, 10/30/08, 02/05/09, 01/08/09
9. EMG study, 12/10/08
10. CT scan of the left wrist, 11/13/08
11. Occupational therapy reports, 11/05/08

12. Physical therapy reports, 10/31/08, 10/30/08, 10/28/08, 10/24/08, 09/25/08, 09/24/08, and 09/17/08
13. Operative report, 06/18/08
14. referral, 02/13/09
15. Request for reconsideration, 02/12/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This unfortunate xx-year-old male suffered an injury to his left wrist in a fall on xx/xx/xx. He underwent open reduction internal fixation of the distal radius fracture with closed treatment of the distal ulna fracture on 06/18/08. He has had persistent discomfort in the wrist with pain and tenderness over the radial scaphoid articulation and the radial styloid process. He has intact light touch sensation but diminished two-point discrimination in the thumb, index, and radial aspect ring finger. He has had no thenar atrophy. He has limited range of pronation and supination, limited range of extension and flexion at the wrist. CT scan of the left wrist dated 01/13/09 demonstrates the comminuted fracture of the distal radius with nonunion, the articular surface irregularity of the radiocarpal joint, degenerative cyst of the capitate, and increased scapholunate interval suggestive of scapholunate disassociation. Electrodiagnostic testing has revealed mild carpal tunnel syndrome without denervation. The requested surgical procedure for removal of hardware of the distal radius with allograft or autograft of the left wrist, open reduction internal fixation of the scaphoid versus excision, and repair of the TFCC with a left carpal tunnel release has been requested. It has been denied. Reconsideration has been requested, and it has been denied.

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

This patient suffered a severe comminuted intra-articular injury to the left wrist approximately ten months prior to this evaluation. Initial treatment consisting of open reduction internal fixation led to nonunion, and there has been the intervening of a very prompt osteoarthritic change. The surgical procedure requested, even if it is successful with fusion and healing of the distal radius fracture is achieved, it is not likely to resolve the pain in the left wrist as a result of the osteoarthritis. The request for preauthorization to remove the hardware and perform a revision of the open reduction internal fixation utilizing allograft or autograft was initially denied, and this decision was appropriate and should be upheld.

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

*(Check any of the following that were used in the course of your review.)*

- \_\_\_\_\_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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)