

## Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 18, 2010

**IRO CASE #:**

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

Diagnostic arthroscopy of right wrist.

**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 42 years of experience.

**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**

On July 1, 2009, the claimant was evaluated by M.D., an orthopedic surgeon. The claimant stated she had pain along the ulnar aspect of her wrist, as well as the palmer surface. Dr. recommended an MRI of the right wrist and a short arm cast to see if the pain and swelling will go down.

On July 1, 2008, x-rays were taken of the right wrist. Impression: 1. Mild osteoarthritis. 2. Minimal ulnar positive configuration as interpreted by., M.D.

On August 14, 2008, the claimant was evaluated by, M.D. She has marked reduction in swelling with pain primarily over the FCU tendon as well as her TFCC. She moves her fingers in full range of motion.

On September 16, 2008, the claimant was re-evaluated by, M.D. She has reduction in edema and decrease in pain.

On September 30, 2008, an MRI of the right wrist was performed. Impression: 1. Wrist joint effusion extending into the DRUJ. 2. Cystic changes in the carpus, likely related to osteoarthritis. 3. TFCC is not optimally evaluated, as the exam was tailored to the distal forearm. 4. Normal appearing mid and distal forearm as interpreted by, M.D.

On October 2, 2008, the claimant was re-evaluated by, M.D. She has a hypersensitivity pain overlying the volar aspect of her hand as well as significant pain with palpation overlying fusiform.

On October 27, 2008, the claimant was re-evaluated by, M.D. Her symptoms have decreased after a Medrol Dosepak and Lyrica. She had decreased swelling of the wrist.

On November 24, 2008, the claimant was re-evaluated by, M.D. She has had a significant amount of occupational therapy. She is having recurrent problems with discoloration, swelling some pain.

On February 20, 2009, an IRO was performed which approved a Stellate Ganglion Block based on the ODG Guidelines.

On March 13, 2009, M.D. performed a designated doctors evaluation. He was asked to address return to work in which he stated she may return to work with the following restrictions: No pushing more than 60 pounds and no pulling more than 52 pounds.

On May 21, 2009, M.D. was asked to determine if the mechanism of injury cause more than just a right wrist fracture. Dr. stated that yes it did as the patient is suffering from RSD of the right upper extremity and findings of a TFCC tear.

On June 23, 2009, M.D. performed a Required Medical Examination. He stated that there are no specific findings of objective injury, and she had degenerative osteoarthritis of the wrist.

On October 28, 2009, the claimant was evaluated by, M.D. She stated she underwent a stellate ganglion block in early October that gave her some symptomatic relief of pain.

On February 10, 2010, the claimant was evaluated by, M.D. She states she is happy with the level of relief from her symptoms. She has decreased irritation, decreased shooting pain in the right hand.

On April 26, 2010, the claimant was re-evaluated by, M.D. She continues to have persistent pain involving her right wrist.

On June 24, 2010, , DO. performed a utilization review on the claimant Rational for Denial: There is no documentation of comprehensive conservative treatment. There is also noted arthritic changes in the MRI that may contribute to the pain generation. MRI findings are not definitive of TFCC pathology. Therefore, it is not certified.

On July 22, 2010, , M.D., an orthopedic surgeon. performed a utilization review on the claimant Rational for Denial: There is no documentation of optimized conservative treatment rendered to the patient and her clinical response to it. Therefore, it is not certified.

**PATIENT CLINICAL HISTORY:**

On xx/xx/xx, the claimant sustained an injury to the left wrist she was removing a pressurized cap off of a truck when it somehow malfunctioned. The cap struck her on the palmar surface of her right hand.

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

The previous decisions are upheld for the following reasons: conservative care has not been exhausted and MRI findings are not definitive of TFCC pathology. Therefore, the request of a diagnostic arthroscopy of right wrist is considered not medically necessary.

Per the ODG Guidelines

*Triangular fibrocartilage complex (TFCC) reconstruction*

*Recommended as an option. Arthroscopic repair of peripheral tears of the triangular fibrocartilage complex (TFCC) is a satisfactory method of repairing these injuries. Injuries to the triangular fibrocartilage complex are a cause of ulnar-sided wrist pain. The TFC is a complex structure that involves the central fibrocartilage articular disc, merging with the volar edge of the ulnocarpal ligaments and, at its dorsal edge, with the floors of the extensor carpi ulnaris and extensor digiti minimi. (Corso, 1997) (Shih, 2000) Triangular fibrocartilage complex (TFCC) tear reconstruction with partial extensor carpi ulnaris tendon combined with or without ulnar shortening procedure is an effective method for post-traumatic chronic TFCC tears with distal radioulnar joint (DRUJ) instability suggested by this study. (Shih, 2005)*

**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)