

SENT VIA EMAIL OR FAX ON  
Jun/30/2010

# Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jun/28/2010

**IRO CASE #:**

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

CTR Left Wrist; Shortening Osteotomy Left Wrist

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

Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic Surgery  
Fellowship Training in Upper Extremities

**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**

OD Guidelines  
Denial Letters 5/21/10 and 6/1/10  
Dr. 2/19/10 thru 4/14/10  
MRI 8/31/09  
EMG Unreadable Date

**PATIENT CLINICAL HISTORY SUMMARY**

The patient has chronic left wrist pain after a work-related injury. The patient also has carpal tunnel syndrome that developed after this injury. MRI scan is consistent with an intact TFCC and ulnocarpal impaction syndrome. The patient's hand surgeon feels that she also has some midcarpal arthritis. The medical records provided do not demonstrate any history of ulnocarpal stirred injections.

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

Although this patient may have a dynamic ulnocarpal impaction syndrome and carpal tunnel syndrome, there are also some confounding, unaddressed issues. The medical records do not provide the rheumatological evaluation in this patient. There is additional work-up that would be helpful in predicting whether or not the proposed ulnar shortening osteotomy would be helpful. There is no comment on laxity of the ulnar carpal ligaments or lunotriquetral ligament. Based on the medical records, the request is not appear to be medically reasonable or necessary at this time. The ODG guidelines do not adequately cover this complex hand/upper extremity case.

**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)  
GREEN'S OPERATIVE HAND SURGERY, FIFTH EDITION

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)