

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 10, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed OP arthroscopic debridement of triangular fibrocartilage complex (TFCC) right wrist

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
813.42	OP arthroscopic debridement of triangular fibrocartilage complex (TFCC) right wrist		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 95 pages of records received to include but not limited to: letter 2.23.10; records Orthopedic Sports and Rehabilitation 2.20.09-1.15.10; Medical Center report xx/xx/xx; MRI Wrist 9.4.09; letters 5.21.09-2.4.10

Respondent records- a total of 85 pages of records received from the URA to include but not limited to: TDI letter 2.18.10; Request for an IRO forms; records Orthopedic Sports and Rehabilitation 5.19.09-1.15.10; letters 1.22.10-2.4.10 letter 8.4.09

Requestor records- a total of 119 pages of records received to include but not limited to: records Orthopedic Sports and Rehabilitation 2.20.09-1.15.10; Medical Center report xx/xx/xx; MRI Wrist 9.4.09; letters 5.20.09-2.4.10; letter 8.4.09; DWC forms 69, 73

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records presented begin with a February 20, 2009; the injured employee had a cabinet fall on her bilateral hands on or about xx/xx/xx. The initial physical examination noted bruising on the dorsum of the left hand and plain films were read as negative. Right hand films noted a right distal radius fracture. Dr. treated this with immobilization and the injured employee reportedly did quite well.

At the two month point, from the date of injury, Dr. reports that there was no tenderness at the fracture site, no deformity and that the injured employee was neurovascularly intact. A range of motion protocol was outlined for Ms.. A decrease to pronation and supination was reported; otherwise, a normal clinical situation existed. By August, Dr. was unsure why there was such a loss of supination from such a minimal deformity.

In October Dr. noted maximum medical improvement and assigned a 1% whole person impairment rating.

Dr. completed an orthopedic consultation, noted some range of motion losses and did not see and distal radioulnar joint abnormality on plain films. The assessment was a joint contracture. The DRUJ was injected. Dr. felt that there might be a compromise to the TFCC. The MRI noted that there was no tearing of the TFCC. Based on the MRI report, tempered by his physical examination, Dr. did not feel that there was a surgical lesion. The injured employee was noted to be making progress with the injection and occupational therapy.

Several months later, the injured employee returned to Dr. who noted the pain complaints, a good range of motion and no instability of the DRUJ. There was point tenderness over the triangular fibrocartilage. The assessment made was a TFCC tear. Arthroscopic surgery was scheduled.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines surgical repair for a TFCC lesion is:

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](#))

In this case, there is no competent, objective and independently confirmable medical evidence of a TFCC lesion. Dr. noted that the wrist was stable. Dr. noted that the wrist MRI did not objectify a surgical lesion. Dr. noted that maximum medical improvement had been reached. With a normal physical examination, (and only a year after the date of injury) there was specific point tenderness. That point modified by the normal MRI and the notation of another provider that maximum medical improvement had been reached, there is insufficient clinical data presented that would support surgical intervention at this time.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)