

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 11/9/2010  
**IRO CASE #:**

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

Outpatient TFC repair with ulnar shortening, scapholunate debridement, possible repair; possible resection of distal third of scaphoid to include CPT codes 29846, 25390 and 25440

**QUALIFICATIONS OF THE REVIEWER:**

Orthopaedics

**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)

Outpatient TFC repair with ulnar shortening, scapholunate debridement, possible repair; possible resection of distal third of scaphoid to include CPT codes 29846, 25390 and 25440 Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Fax page dated 11/3/2010
2. Notice to utilization review dated 11/1/2010
3. Notice to air analysis by dated 11/1/2010
4. Confirmation of receipt by author unknown, dated 10/29/2010
5. Request form by author unknown, dated 10/28/2010
6. Notes by MD, dated 10/6/2010 & 10/7/2010
7. History note by MD, dated 9/23/2010
8. History note by MD, dated 9/2/2010
9. Concurrent review determination by author unknown, dated 8/20/2010 to 10/8/2010
10. History note by author unknown, dated 8/19/2010 & 9/2/2010
11. History note by dated 7/29/2010
12. Diagnostic imaging report by dated 7/15/2010
13. Therapeutic exercise sheet dated 7/12/2010
14. Soap note by dated 7/6/2010 to 7/12/2010
15. Notice of disputed issue dated 7/1/2010 & 9/10/2010
16. Soap note by, dated 6/25/2010 & 7/1/2010
17. Therapeutic exercise sheet by dated 6/25/2010
18. Soap note by dated 6/4/2010

Name: Patient\_Name

19. History note by dated 6/3/2010 to 8/19/2010
20. History note by MD, dated 5/26/2010 to 7/14/2010
21. First report of injury by author unknown, dated 5/24/2010
22. Letter by MD, dated unknown
23. Musculoskeletal system dated unknown

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The patient is a injured employee who sustained an injury on xx/xx/xx when she tripped and fell, landing on her right wrist. Initial exam revealed tenderness at the right wrist with flexion and extension, slightly positive Phalen's test, and negative Tinel's sign. The injured employee was prescribed prednisone and dexamethasone along with Vicodin. The injured employee was also provided a wrist splint. The injured employee began physical therapy on 06/04/2010 and continued through 07/12/2010. MRI of the right wrist dated 07/15/2010 revealed a tear of the triangular fibrocartilaginous complex with an edema through the triquetral which suggested a healing fracture. Follow-up on 07/21/2010 indicated the injured employee was wearing a brace at all times and continued to have pain in the ulnar aspect of the right wrist. Physical exam revealed tenderness to palpation over the ulnar aspect of the right wrist. The injured employee was referred for a consult with Dr. which was performed on 07/29/2010. Physical exam revealed mild loss of range of motion in the right wrist, flexion, extension, and ulnar radial deviation. The injured employee was recommended for TFC repair and ulnar shortening. Follow-up on 09/23/2010 stated the injured employee continued to have pain in the right wrist and did not respond in the long term to injections performed. The injured employee stated that previous injections lasted approximately one week. Physical exam was relatively unchanged and the injured employee was again recommended for a TFC repair.

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

The prior denials are upheld. Although the patient has evidence on the MRI studies of a TFC tear, there is no evidence in the MRI study to suggest any carpal instability that would reasonably require resection of the distal 3rd of the scaphoid or scapholunate debridement that would reasonably address carpal instability. Without objective documentation of evidence of carpal instability, medical necessity would not be supported in this case. As such, the prior denials are upheld.

**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)