



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 10-21-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Release of A1 pulley of the right ring flexor tendon sheath

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

American Board of Orthopaedic Surgery-Board Certified

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

- MD., office visits on 9-3-08, 10-29-08, 12-3-08, 1-8-09, 1-16-08, 2-11-09, 3-16-09, 8-9-10, 8-23-10, and 9-10-10.
- MRI post arthrogram of the right wrist dated 11-19-08.
- 1-8-09 Surgery performed by MD.
- 6-23-10 MD., office visit.
- 7-29-10 MRI of the right wrist without contrast.
- 9-1-10 MD., Utilization Review.
- A letter provided by Dr. on 9-10-10 notes.
- 9-21-10 MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx MD., evaluated the claimant. He reported the claimant is xx years old. She is right hand dominant. She is a xxx. I am seeing her today at the request of Dr. for an injury sustained by the patient while at work three weeks ago. She was pulling a dolly. The dolly's front wheel got stuck on a door jam as she was turning the corner and twisted her right wrist. She did not feel a pop but she felt a pull and has been having ulnar sided wrist pain since then. It has been persistently swollen and has not gotten better. He was seeing her for evaluation of this problem. Examination of the right upper extremity demonstrates focal tenderness over the TFCC. She has mild tenderness over the lunotriquetral interval with a moderately positive Lindsheid Kleinmann's, however, is not provocative. She has painful extension and ulnar deviation. There is no obvious clicking or popping with pronosupination. There is no noted instability of the DRUJ. The ECU is minimally tender. She does have a positive push off. There is no tenderness in the central wrist dorsum. The scapholunate interval is not provocative. The snuff box is nontender. Small joint range of motion is supple. Detailed exam demonstrates full range of motion at shoulder and elbow without evidence of subluxation or dislocation. Proximal and distal motors are 5/5. Skin is without atrophic change, adenopathy, ecchymosis or open wounds and distal pulses are palpable. Impression: TFCC tear of the right wrist.

The evaluator discussed cortisone injection into the ulnar wrist dorsum. The claimant says that she has had had experiences with Cortisone in the past and would prefer not to have a Cortisone shot. That being discussed, he was going to put the patient in a wrist gauntlet splint that he wanted her to wear with the exception of bathing over the next three to four weeks.

On 9-3-08, Dr. reported that radiographs include two views of the right wrist which fail to elicit gross bony abnormality. The patient is 2 mm ulnar negative and there is no evidence of dorsal or volar intercalated malalignment of the lunate.

On 10-29-08, Dr. reported that the claimant is now about one month out from when we recommended cast treatment. She came in on one occasion to have her cast changed and then removed her cast last week because it the wrist was mobile in the cast. She says the wrist felt better for several days but is now hurting again. Exam today demonstrates tenderness over the triangular fibrocartilage complex. There is no obvious clicking or popping but push-off remains positive. The evaluator was going to send her for an MRI arthrogram for the right wrist.

MRI post arthrogram of the right wrist dated 11-19-08 showed there is extravasation of contrast into the distal radioulnar joint, consistent with suspected history of TFCC tear. There is no contrast extravasation into the midcarpal space to suggest interosseous ligament tear. There is longitudinal signal alteration within the extensor carpi ulnaris tendon at the level of the inner styloid process, just proximally and distally. It is unclear whether this represents a longitudinal split tear or severe tendinosis. Split tear is suspected. There is also surrounding edema. There is no acute fracture, dislocation or avascular necrosis. There are no soft tissue masses or ganglion cysts identified.

Follow up with Dr. on 12-3-08 notes the claimant had the MRI arthrogram which clearly demonstrates a TFCC complex tear. The evaluator recommended arthroscopy.

On 1-8-09, , MD., notes that the claimant is a xx-year-old, right-hand dominant woman who is a xx . She was originally referred for evaluation of injury that occurred in xx while pulling a dolly. The dolly's front wheel got stuck in a door jam as she was turning a corner, and her wrist twisted. She began having ulnar-sided wrist pain thereafter. Examination was consistent with triangular fibrocartilaginous complex tear. MR arthrogram was confirmatory. She failed nonoperative treatment and presents for surgical management. Examination of the right upper extremity demonstrates focal tenderness over the triangular fibrocartilaginous complex with mild tenderness over the LT interval. Moderate Linscheid Kleinman is not provocative. She has painful extension and ulnar deviation. No obvious clicking or popping with pronation-supination. No noted DRUJ instability. She has markedly positive pushoff. No tenderness in the central wrist dorsum. Scapholunate interval is stable. The snuffbox is nontender. Small joint range of motion is otherwise supple. Radiographs of the wrist including two views of the right wrist fail to elicit gross bony abnormality other than a 2-mm ulnar negative variant and no evidence of malalignment of the intracarpal indices. MR arthrogram demonstrates triangular fibrocartilaginous complex tear. Impression: Internal derangement, right wrist,

likely triangular fibrocartilaginous complex tear. Recommendations: Proceed with diagnostic and therapeutic arthroscopy.

1-8-09 Surgery performed by MD: Right wrist arthroscopy with triangular fibrocartilaginous complex debridement.

Follow up with Dr. on 1-16-09 notes that the claimant is a week status post wrist arthroscopy. He identified a class 1, type A tear of the triangular fibrocartilage complex and debrided it for her. She presents for her first postoperative visit. She has been off work since surgery. Exam today demonstrates healed portals with no sign of infection. Some tenderness over the ulnar wrist dorsum. She has some fading ecchymoses over the dorsoulnar hand dorsum. The evaluator was going to place the claimant into a gauntlet splint for comfort. He wanted her to avoid lining, twisting, pushing or pulling activities for another three weeks which will preclude her from returning to work since she tells me there is no light duty available. He will see her back in three weeks for a recheck and depending on her recovery; he will consider return-to-work issues at that time. He asked the claimant to begin gentle range of motion exercises on her own. At this time, he saw no indication for formal therapy; however, that may change depending on her overall recovery.

Follow up with Dr. on 2-11-09 notes the claimant is about a month out. She presents for a followup. She has been feeling much better and feels like she is going to be able to go back to work. She still notes ulnar sided wrist pain with loading and some tenderness over the central portal.

On 3-16-09 MD., reports that the claimant is now nine weeks out. She is working full duty without problems. Exam today demonstrates supple range of motion. No clicking or popping or distal radioulnar joint instability. Impression: Class 1, type A triangular fibrocartilage complex tear, status post arthroscopic debridement, right wrist Plan: the evaluator was pleased with the claimant's result. He will pronounce maximum medical improvement at this time and send her for an impairment rating evaluation.

On 6-23-10, the claimant was evaluated by, MD., the claimant is a xx year old female employee of xxx. The patient injured her right wrist on xx/xx/xx, now two days ago. She states that she and a co-worker were lifting a crate, the weight shifted and the patient twisted her wrist and heard a pop. She complains of pain about the ulnar aspect of her wrist. She also complains of some pain in the palm over the head of the ring finger metacarpal. Examination of her right wrist reveals limited range of motion with tenderness over the ulnar aspect of her wrist. She does have tenderness over the distal radial joint. She has some tenderness over the palmar aspect of the fourth metacarpal head. No neurovascular deficit is noted. No other deficits are noted. X-rays brought with the patient are reviewed and are within normal limits. Impression: Right wrist sprain with possibility of another TFCC tear. Plan: He will let her continue doing her normal work with the use of the splint. I will refer her back to Dr. Kramer for his opinion and treatment. She will return to work and her limitations with using the splint are in effect through July 23, 2010.

7-29-10 MRI of the right wrist without contrast showed marked thinning of the radial aspect of the articular disc is concerning for a possible tear or postop changes. Correlation with wrist injection report may be helpful. Small effusion in the pre styloid recess. DRUJ and dorsal radial aspect of the wrist. Scapholunate and lunotriquetral ligaments are preserved. Subchondral cystic changes in the proximal ulnar aspect of the lunate may represent an ulnar abutment syndrome.

Follow up with Dr. on 8-9-10 notes the MRI arthrogram was performed and he reviewed it. On exam, the claimant had exquisitely tender over the ECU. There is the sensation that this is subluxed ulnarward. However, there is enough crepitation and swelling in and around the area that this may be inflammatory in nature. The evaluator performed a corticosteroid injection into the ECU tendon sheath. Postop exam showed minimal change. The claimant was started on Mobic. The evaluator reported that at this time he was less inclined to recommend any type of surgical intervention with respect of the wrist until he see a response or not to the injection. The claimant was returned to work without restrictions.

Follow up with Dr. on 8-23-10 notes the evaluator performed an injection into the extensor carpi ulnaris sheath at the last visit. The injection he provided into her extensor carpi ulnaris sheath worked for a day or two and then the pain came back. Exam today demonstrates focal tenderness over extensor carpi ulnaris tendon just proximal to its insertion on the fifth metacarpal base. She is minimally tender over the triangular fibrocartilage complex. She has a friction rub with range of motion and a positive ECU synergy test. She has persistent locking or the ring finger in flexion. Impression: Extensor carpi ulnaris tendonitis, right wrist and stenosing flexor tenosynovitis, right ring. Plan: the evaluator discussed alternatives, risks, benefits, and complications of operative and nonoperative treatment. He believed the patient is a candidate for release of the A1 pulley of the right ring flexor tendon sheath as well. He would recommend a sixth dorsal compartment retinacular release. She wants to proceed. He will put her on the schedule for this combined procedure and hopefully get this approved through her comp carrier and of course follow her closely thereafter.

On 9-1-10, MD., performed a Utilization Review. He noted that this xx year old IW with date of injury xx/xx/xx appears to have a tendinitis of the extensor carpi ulnar, associated with tenderness and local crepitus. This area has been injected with steroid affording her a couple days relief. There is no indication that her trigger finger has had any treatment. Since the request seems to be premature, it cannot be considered reasonable or medically necessary.

Follow up with, MD., on 9-10-10 notes the claimant is being seen, as her surgery has apparently been denied. I have not received any attempted phone contact nor have I received anything at all in writing to deny our surgical opinion. However, when trying to schedule the surgery we were given a verbal over the telephone that it was denied. The evaluator discussed this with the patient and he had written a letter to the appropriate adjustor and recommended to my patient that she formerly complain to the Texas

Insurance Commission. He will wait to see how her insurance company responds and he will give her a 2 week follow-up appointment.

A letter provided by Dr. on 9-10-10 notes "It has come to my attention that the patient's surgery has been denied. I have not received a denial letter from your company nor have I received an attempted phone contact from anyone reviewing her case. She has had the gamete of nonoperative treatment including splint wear, anti-inflammatory medications, and injections. She has had advanced imaging to suggest the pathology and has not responded to nonoperative treatment. This patient has clear-cut surgical indications and I understand that she was denied for her surgery being not medically necessary. I am advising my patient to contact the Texas Insurance Commission to complain regarding this denial. My opinion does not change and I understand this pathology very well. I do look forward to the physician who reviewed these records to put in writing his or her opinion as to why my patient's surgery is not medically necessary and I would certainly hope that his or her opinion would understand the scrutiny of his or her peers as I am a Board Certified and Fellowship trained surgeon with credentials in hand and upper extremity surgery and do nothing other than surgery on the hand and upper extremity and have for many years. I would certainly hope that the person reviewing my patient's records has similar credentials to mine and would be willing to discuss his or her opinion with me in writing. I look forward to that_ In the meantime, my patient will actively pursue her complaint against to the Texas Insurance Commission in hopes to get this problem resolved."

On 9-21-10, MD., performed a Utilization Review. It was his opinion that for the described right ring trigger finger, there remains no report of specific nonoperative treatment for the right ring finger (injection and splinting for the ECU is reported, not for the ring finger) and no stated contraindication to nonoperative treatment for ring finger triggering, so the medical necessity of right ring trigger finger release is not established.

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

The claimant has symptomatic tenosynovitis of the affected ring finger. However, the only objective findings discuss tenderness and "locking of the ring finger in flexion." It is not evident or clear that the claimant has a true locked or neurovascularly compromised digit. It is also not evident that the claimant is having to manually 'unlock' the affected finger. There has been evidence of imaging and injections of the wrist pathology, however a record review does not evidence that the 'trigger finger' itself has had an attempt of non-operative injection treatment. Therefore as per applicable guidelines, the proposed procedure does not appear medically necessary or reasonably required at this time.

ODG-TWC, last update 10-8-10 Occupational Disorders of the forearm, wrist and hand – trigger finger release: Recommended where symptoms persist. Trigger finger is a condition in which the finger becomes locked in a bent position because of an inflamed and swollen tendon. In cases where symptoms persist after steroid injection,

surgery may be recommended. However, the risk of troublesome complications, even after this minor operation, should be born in mind. (Finsen, 2003) One hundred and eighty patients with 240 trigger digits were treated by percutaneous release using a 'lift-cut' technique. All patients were reviewed at 3 months following release. Overall, 94% achieved an excellent or good result. Ten patients experienced recurrent symptoms and required a subsequent open release. There was no clinical evidence of digital nerve or flexor tendon injury. (Ragoowansi, 2005) According to one study, percutaneous release with steroid injection of trigger thumbs is a cheap, safe and effective procedure with a low rate of complications. (Cebesoy, 2006) Percutaneous release with steroid injection produced satisfactory long-term results in 91% of cases whereas steroid injection alone produced satisfactory results in 47% of cases. Percutaneous trigger thumb release combined with steroid injection has a higher success rate than that of steroid injection alone. (Maneerit, 2003) Surgical release of the A1 pulley for treatment of trigger finger normally produces excellent results. However, in patients with long-standing disease, there may be a persistent fixed flexion deformity of the proximal interphalangeal joint due to a degenerative thickening of the flexor tendons. Treatment by resection of the ulnar slip of flexor digitorum superficialis tendon is indicated for patients with loss passive extension in the proximal interphalangeal joint and a long history of triggering. (Le Viet, 2004) (Fu, 2006) One study concluded that surgical outcome for trigger finger was poorer than that for trigger thumb, partly due to flexion contracture of the PIP joint.

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)**