



## Medwork Independent Review

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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Network (WCN)*

#### *MEDWORK INDEPENDENT REVIEW DECISION (WCN)*

**DATE OF REVIEW: 09/01/2010**

**IRO CASE #:**

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

Left wrist scope for TFCC (29846)

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

Texas State Licensed MD Board Certified Orthopedic Surgeon

**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**

1. Assignment to 08/13/2010
2. Notice of assignment to URA 08/13/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 08/11/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/11/2010
6. 08/06/2010, 06/07/2010, carrier submission 08/18/2010, DD exam 07/27/2010, note 07/22/2010, 07/13/2010, peer review 06/02/2010, 05/19/2010, 05/27/2010, 05/19/2010, 05/07/2010, 04/29/2010, 04/20/2010, 04/08/2010, 02/04/2010, 01/14/2010, 12/16/2009, 12/09/2009, 12/07/2009, peer review 11/25/2009, 11/24/2009, 11/12/2009, 11/09/2009, 10/29/2009, 10/13/2009, 09/29/2009, 09/21/2009, 09/15/2009, 09/14/2009, 09/10/2009, 09/01/2009, 08/24/2009, 08/21/2009, 08/20/2009, 08/18/2009, 08/17/2009, TDI forms 07/27/2010, 07/15/2010, 05/12/2010, 04/29/2010, 04/08/2010, 02/25/2010, 02/13/2010, 02/07/2010, 02/04/2010, 12/12/2009, 11/15/2009, 10/31/2009, 10/01/2009, 09/17/2009, 09/04/2009, 08/27/2009, 08/20/2009
7. ODG guidelines were provided by the URA

**PATIENT CLINICAL HISTORY:**

The patient was involved in a lifting injury on xx/xx/xx. Since that time he has had pain about the left wrist. Although there is some reference to conservative treatment there is no documentation of that. EMGs were carried out. These confirmed a left carpal tunnel syndrome.



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MRI scan was carried out. This showed an interosseous cystic change within the lunate without evidence of collapse. There was irregular signal morphology consistent with degeneration and intrasubstance tearing and perforation of the triangular fibrocartilaginous complex. There was a possible ganglion. There was widening of the distal radioulnar joint with some small amount of fluid. X-rays were undertaken. This showed an ulnar plus variation and a lunate cyst. The patient was recommended to have updated EMGs and nerve conduction velocity testing. This was subsequently carried out. This showed evidence of advanced left sensory motor median neuropathy consistent with left carpal tunnel syndrome. Request is for left wrist scope for TFCC (29846).

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

Using the current Official Disability guidelines along with the review of the medical records provided, there is inadequate documentation of conservative treatment to this patient. Using ODG guidelines it is unreasonable to approve a left wrist scope for TFCC (29846). This patient does not fulfill the criteria; therefore, the adverse determination is upheld for the requested.

### **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)