

IRO Case # 32549

February 2, 2011

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Notice of Independent Review Decision

DATE OF REVIEW: February 2, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left wrist arthroscopy, debridement, TFCC repair and partial ECU release.

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

AMERICAN BOARD OF PLASTIC SURGERY
AMERICAN BOARD OF OTOLARYNGOLOGY

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

PATIENT CLINICAL HISTORY:

The question I was asked briefly was to review the medical records of the above-referenced patient and case, which revolved around a request for additional services listed on the enclosed records. The basic question was a request on this patient for a left wrist arthroscopy, debridement, triangular fibrocartilage complex repair, and partial extensor carpi ulnaris release. There have been several reviews already listed. Both of these denied the services. I was asked to provide an independent review of the medical records as they were sent to me. This included a review of the previous denials. I would uphold the previous determinations as non-certifying the requested services.

The patient is a xx-year-old female who sustained an injury on. This was a work- related injury. The exact details are not listed.

The patient did have studies which were listed in the enclosed medical records, including EMG, MRI arthrogram.

The patient had complaints of left wrist pain and underwent surgeries in September of 2010 to address a carpal tunnel and de Quervain's type problem, as well as a cubital tunnel problem. These were performed by the treating physician whose note was reviewed. His follow-up notes were also reviewed. The patient seemed to have benefitted from this surgery.

There are no strong indicators of the ulnar-sided wrist pain in the records that were enclosed. These are listed by the treating physician in several instances, however, without specific details as to the provocative signs.

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

There is not convincing evidence to certify the requested procedures. These are based in part on the ODG Guidelines. The MRI was suggestive of a triangular fibrocartilage complex tear, and the clinical complaints appear mild. I would, therefore, uphold the previous determinations.

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

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TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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