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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 01/17/2011

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP: Left wrist arthroscopy with TFCC debridement and possible partial synovectomy 29844 29846

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-20-10 Initial examination report from Dr.
- o 03-29-10 Radiographic studies from Dr.
- o 04-07-10 Orthopedic follow up report from Dr.
- o 04-08-10 Precert request for wrist surgery from Dr.
- o 04-27-10 Operative report from Dr.
- o 07-09-10 Evaluation report from Dr.
- o 07-12-10 Progress report from, LOT
- o 07-19-10 Progress report from, OTR
- o 07-21-10 Progress report from, OTR
- o 07-23-10 Discharge Summary from, OTR
- o 07-30-10 Orthopedic follow up report from Dr.
- o 08-30-10 Orthopedic follow up report from Dr.
- o 10-01-10 Orthopedic follow up report from Dr.
- o 11-01-10 Orthopedic follow up report from Dr.
- o 11-22-10 Orthopedic follow up report from Dr.
- o 12-02-10 Notification of Adverse Determination
- o 12-10-10 Reconsideration request for left wrist arthroscopy from Dr.
- o 12-20-10 Appeal for left wrist arthroscopy from Dr.

- o 01-03-11 Notification of Adverse Determination on reconsideration
- o 0x-03-10 Fax cover appeal from unsigned
- o 01-03-11 Request for IRO from the Claimant
- o 01-05-11 Confirmation of Receipt of Request for IRO from TDI
- o 01-05-11 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the bilateral wrists on xx/xx/xx. He sustained bilateral wrist fractures and was treated with close treatment for a right scaphoid fracture and ORIF for a left scaphoid fracture.

The patient was examined orthopedically on March 29, 2010. He describes a fall from a truck and landing on both wrists. His wrists were behind his back. He was placed in a splint for a possible fracture and sent for evaluation. He describes bilateral wrist pain left more than right. There is swelling at both wrists and pain with range of motion. Radiographs showed a non-displaced fracture through the left scaphoid and a possible non-displaced fracture through the right scaphoid as well as slight lucency seen on the radial aspect of the capitate. He will return after MRI is done.

On April 7, 2010 the patient is off work and states he wants a surgery on his wrist. He has not yet had the wrist MRI. He is tired of wearing the bilateral thumb spica cast. The cast is removed from the left wrist. He has full strength and sensation is intact. There is tenderness over the anatomical snuffbox. The right wrist is left with the cast on as it is fitting well. X-rays showed no obvious fracture or dislocation on the right and a non-displaced scaphoid fracture on the left. Request was made for outpatient ORIF scaphoid fractures bilateral wrists.

The operative report dated April 27, 2010 describes findings of non-displaced fracture of the left scaphoid and non-displaced right scaphoid fracture with no latency of the fracture site. Procedures included ORIF left scaphoid and closed treatment, right scaphoid.

At reevaluation of July 9, 2010 the patient reported both wrists are improving but the left wrist remains stiff, especially with extension. There is no tenderness over the anatomical snuffbox right or left. He will complete therapy. An FCE is recommended. Work restrictions are provided (10 lb lifting limit).

Therapy notes of July 12, 2010 indicate therapy content of active and passive modalities. An additional 8-12 visits are planned. On July 19, 2010 the therapist noted he is doing light duty with no lifting. He continues to report discomfort and pain with popping with wrist flexion and extension. Coban wrap and iontophoresis are added to his regimen.

Occupational therapy Discharge Summary dated July 23, 2010 notes the patient underwent closed reduction of the right wrist and open reduction of the left wrist to correct scaphoid fractures on April 27, 2010. He reports locking of his left wrist with flexion and a popping sensation along the ulnar aspect of the wrist. Wrist supination was improved from 78 degrees to 80 degrees, forearm pronation from 80 degrees to 90 degrees, wrist flexion from 35 degrees to 45 degrees, wrist extension from 52 degrees to 60 degrees, radial deviation from 15 degrees to 20 degrees. Ulnar deviation remains at 25 degrees. 2-point discrimination is intact. His active ROM of the bilateral upper extremities is within normal. He is now able to make a complete fist and has gained 51 pounds of grip strength. He remains with mild discomfort with weight bearing activities. He has returned to work and does not report any discomfort with work activities.

At reevaluation on July 30, 2010 the patient states his wrists are getting better. He has some mild stiffness in the left wrist with occasional crepitation. He is currently demonstrating the ability to return to full work duty.

On August 30, 2010 the provider noted that the patient was seen by a Designated Doctor and found not to be at MMI as he requires additional treatment for the back and hip. With regard to the left wrist, he is also not at MMI as he continues to have some pain with stiffness, particularly with extension and ulnar deviation. X-rays were taken and showed healed scaphoid fracture with no evidence of loosening of lucency of the screw.

On October 1, 2010 the patient reports occasional pain and clicking in the left wrist. On examination, slight palpable crepitation and clicking is noted at the left wrist, diffuse in nature. It appears to be more prominent on the ulnar aspect of the wrist. He also has pain with terminal extension of the wrist. He may require additional diagnostic studies.

On November 1, 2010 the patient's complaints remain unchanged. Multiple radiographic views were taken with no abnormalities noted. He may have a small loose body or mild ligamentous instability. An MRI would be ordered. He may ultimately require an arthroscopy. Report of November 22, 2010 indicates an MRI was performed. According to the provider, the impression states: Prior ORIF scaphoid fracture with interosseous screw. A small amount of edema in the proximal aspect of the scaphoid bone. Multiple cysts and edema. Triquetral bone was good. Posttraumatic changes, tear of the ulnar attachment, triangular fibrocartilage complex. The provider reviewed the scans and interprets: There is increased signal at the periphery of the TFCC. There is fluid dorsal to the scaphoid and capitate, which may represent a small interosseous ganglion versus synovitis. The patient is not interested in an injection and desires an arthroscopy. This would be done to assess not only the TFCC, but also the radiocarpal and midcarpal joints to rule out potential loose body, assess the articular surfaces of the scaphoid and radius, as well as possible decompression of small ganglion if found in surgery. He can continue regular duty.

Request for left wrist arthroscopy with TFCC debridement and possible partial synovectomy was considered in review on December 2, 2010 with recommendation for non-certification. 32 pages of medical records were reviewed. A peer discussion

was attempted but not realized. Per the reviewer, the patient fell of his trailer and had surgeries to the wrists. An unofficial MRI report was reviewed which showed: Prior ORIF scaphoid fracture with interosseous screw, small amount of edema in the proximal aspect of the scaphoid bone, multiple cysts and edema, triquetral bone is good, post traumatic changes, tear of the

ulnar attachment, triangular complex. Unspecified x-ray, undated, unofficial result: Healed scaphoid fracture, no evidence of loosening or migration of hardware. Reason given for the surgery was, to assess TFCC, radiocarpal and midcarpal joints to rule out potential loose body. ODG supports repair of torn TFCC. ODG does not specifically address the request for wrist arthroscopy and possible partial synovectomy. Medical Practice standard of care dictates surgical consultation/intervention may be indicated for patients with wrist/hand complaints who: Have red flags of a serious nature, fail to respond to conservative management (including splinting and injections), have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The patient has clicking in the wrist, intermittent crepitation and no numbness or tingling. There is symmetric ROM. There is tenderness but no swelling or warmth. Treatment has included medication, splinting and activity modification. However, there is no documentation of special study evidence (formal MRI report) of a lesion that has been shown to benefit from surgical repair.

Letter of appeal dated December 20, 2010 states both the patient's fractures have healed, however, he continues to report pain and crepitation at the left wrist. A recent MRI showed a healed fracture of the scaphoid with post-traumatic changes and a tear of the TFCC. He has been treated with anti-inflammatory medication and therapy without any relief. He is not interested in injection. An arthroscopy is needed to evaluate the articular surfaces of the scaphoid and radius, rule out the potential for loose body (as well as loose bodies) as well as assess the TFCC which may require debridement/repair.

Request for reconsideration left wrist arthroscopy with TFCC debridement and possible partial synovectomy was considered in review on January 3, 2010 with recommendation for non-certification. Per the reviewer, the patient was treated with close treatment on the right scaphoid fracture and ORIF on the left scaphoid. He has completed 12 sessions of PT. The fractures have healed, but he continues to report pain and crepitation at the left wrist. Rationale for arthroscopy is to evaluate the articular surfaces of the scaphoid and radius, rule out the potential for loose body (as well as loose bodies) as well as assess the TFCC which may require debridement/repair. A peer discussion was attempted but not realized. Per guidelines, diagnostic arthroscopy is recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. TFCC reconstruction is supported as an effective method for post-traumatic chronic TFCC tears with distal radioulnar joint (DRUJ) instability. Injury to the TFCC are a cause of ulnar-sided wrist pain. Rationale for denial states, the official MRI was not included for review. Furthermore, there was a lack of imaging evidence to support a TFCC debridement.

Request was made for an IRO.

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

ODG Wrist - Diagnostic arthroscopy: Recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. Patients with marked persistent post-traumatic symptoms despite conservative management are likely to have sustained ligament injuries despite normal radiographs. It is recommended that under these circumstances an arthroscopy may be carried out as soon as 4 weeks if the patient and surgeon wish to acutely repair significant ligament injuries.

Injuries to the triangular fibrocartilage complex are a cause of ulnar-sided wrist pain. 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.

The patient has ulnar sided wrist pain with clicking and locking unresponsive to anti-inflammatory medication, PT and bracing. First and second line review rationale for denial is essentially lack of a formal official MRI report. Per the provider, the MRI report states, prior ORIF scaphoid fracture with interosseous screw, small amount of edema in the proximal aspect of the scaphoid bone, multiple cysts and edema, triquetral bone is good, post traumatic changes, tear of the ulnar attachment, triangular complex. Per the DD at the end of August 2010 the patient is not at MMI as he continues to have some pain with stiffness, particularly with extension and ulnar deviation X-rays are negative. Given the ulnar attachment tearing, negative x-rays and continuation of symptoms beyond 4-12 weeks despite conservative treatments, it would be reasonable to proceed with the recommended arthroscopy.

Therefore, my recommendation is to disagree with the previous non-certification for left wrist arthroscopy with TFCC debridement and possible partial synovectomy.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines 12-20-201- Forearm, Wrist and Hand: Diagnostic arthroscopy:

Recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. This study assessed the role of diagnostic arthroscopy following a wrist injury in patients with normal standard radiographs, an unclear clinical diagnosis and persistent severe pain at 4 to 12 weeks. Patients with marked persistent post-traumatic symptoms despite conservative management are likely to have sustained ligament injuries despite normal radiographs. It is recommended that under these circumstances an arthroscopy may be carried out as soon as 4 weeks if the patient and surgeon wish to acutely repair significant ligament injuries.

Triangular fibrocartilage complex (TFCC) reconstruction:

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. 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.