CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 30, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

R wrist ECU tenolysis; 6th dorsal compartment release vs reconstruction

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

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

April 4, 2006: Mr. attended physical therapy at. She was diagnosed with wrist tenosynovitis. A DWC form 73 was completed by Dr., MD allowing Mr. to return to work without restrictions.

April 12, 2006: Mr. spoke to an investigator over the telephone regarding his condition.

April 18, 2006: A notice of certification letter was sent recommending 6 occupational therapy sessions for the right wrist.

April 28, 2006: An Essential Function Job Analysis was completed on Mr..

May 15, 2006: A utilization review was done by Dr. M.D., who felt that documentation supported the current symptoms and physical findings are causally related to the work injury; there was documentation to support pre-existing conditions/injury that may have aggravated by the work injury; there was documentation that supported the current treatment; and for Mr. to follow up with the treating physician on an every 6 weeks basis to document his symptoms, take over-the-counter medications, future diagnostics tests, and wrist splints for DME.

May 30, 2006: Mr. attended occupational therapy.

June 6, 2006: Mr. attended occupational therapy.

June 8, 2006: Mr. attended occupational therapy.

June 14, 2006: Mr. attended occupational therapy.

June 28, 2006: Mr. attended occupational therapy. He was discharged from occupational therapy. It was noted that he made a good recovery and should do fine as long as he continues his home exercise program.

September 9, 2010: X-ray- Wrist 2 views (read by MD) Impression**:** normal right wrist. Mr. was examined by Dr. MD. He assessed him with carpal tunnel syndrome. He decided to screen Mr. for brachial plexus and referred him to Dr. for nerve conduction studies, and then orthopedics for further treatment and evaluation.

September 15, 2010: Electromyography and Nerve Conduction Study (By, MD) Interpretation**:** There is no electrodiagnostic evidence for an entrapment neuropathy, peripheral neuropathy or brachial plexopathy.

October 5, 2010: Mr. was examined by Dr. M.D., who assessed him to have joint pain of the right wrist and FCU and ECU tendonitis of the right wrist. He felt that Mr. pain was due to overuse due to his occupation. He recommended an MRI to further evaluate his soft tissues. He also recommended that he place Mr. in formal occupational therapy. A DWC form 73 was completed by Dr. MD., allowing Mr. to return to work without restrictions. PE: No tenderness over the

TFCC complex, no tenderness over the FCU tendons, and no tenderness over the ECU tendons.

October 12, 2010: MRA Upper Extremity RT (read by, MD) **Impression:** No evidence for vascular stenosis or occlusion involving the arterial structure of the distal right upper extremity. There is a hairpin-like turn of the ulnar artery as it passes the ulnocarpal joint and proximal to guyon's canal. This anatomic course is of unknown significance. There is no evidence for stenosis or occlusion of the ulnar artery and the superficial and deep palmar arches of the hand appear intact. There have been a few case reports of a tortuous ulnar artery causing ulnar neuropathy. Recommend correlation with physical exam and other neurological diagnostic tests.

October 15, 2010: Mr. was examined by Dr. M.D., who did not have an exact diagnosis and referred him to see Dr. to rule out vascular insufficiency, ulnar side of the right wrist. A DWC form 73 was completed by Dr. MD., allowing Mr. to return to work without restrictions. PE: No tenderness over the ECU tendon. Increased discomfort in the palm of the and with compression over the ulnar artery.

October 19, 2010: Mr. was examined by Dr. MD who suspected some inflammation, nerve irritation and ECU instability. Mr. received an injection to his right hand at the 6th dorsal compartment. A DWC form 73 was completed by Dr. MD., allowing Mr. to return to work without restrictions.

October 29, 2010: A peer review was done by Dr. MD, who felt that the effects of the compensable event of have resolved. He stated, "The claimant had no objectified clinical findings of the right wrist, has no peripheral nerve entrapment, peripheral neuropathy, or brachial plexopathy documented by electrodiagnostic testing. Without neurologic compromise, vascular compromise, direct trauma, without evidence of soft tissue swelling or soft tissue injury, or joint arthritis the claimant requires no further office visits, diagnostic testing, medications, physical therapy, chiropractic care, work hardening or work conditioning, chronic pain management program, individual psychological counseling, injections, or surgery. There are absolutely no objectified clinical findings or documented imaging findings of any pathology as directly related to the right wrist from the compensable injury of."

December 2, 2010: Mr. was examined by Dr. MD who gave Mr. another cortisone injection in the right hand. PE: Mild tenderness to palpation over the ECU tendons.

January 20, 2011: Mr. was examined by Dr. MD who gave Mr. another cortisone injection in the right hand. PE: Tenderness over the FCR tendons and ECU tendons.

March 3, 2011: Mr. was examined by Dr. MD who gave Mr. another cortisone injection in the right hand.

April 14, 2011: Mr. was examined by Dr. MD who gave Mr. the option of a surgical intervention.

April 20, 2011: M.D. performed an UR on the claimant. Rationale for Denial: MR arthrogram of the wrist to rule out a torn TFCC.

April 28, 2011: M.D. performed an UR on the claimant. Rationale for Denial: There is no comprehensive right wrist examination presented for review. No documentation presented of tests and maneuvers done indicating the wrist pathology.

May 5, 2011: MR Arthrogram right wrist (read by Tamina Blais) **Impression:** Well-corticated 9 mm ossification just proximal to the dorsal base of the metacarpal for the middle finger may represent an accessory or old non-united fracture fragment. Subcortical cysis are noted within this ossification as well as within the opposing metacarpal base, suggesting abnormal motion which may be symptomatic. This cortical resolution is somewhat limited on MRI scan, and lateral plain x-ray or CT scan would be helpful for further evaluation. Ligaments in the wrist are confirmed to maintain integrity. Tendons about the wrist reveal no obvious abnormalities. **Right Wrist Arthrogram** (read by Tamina Blais) **Findings:** Contrast injected into the dorsal radioscaphold articulation diffuses freely throughout the radiocarpal joint. There was no fluoroscopic evidence of contrast extension into the intercarpal or distal radioulnar joint spaces. MRI to follow.

May 12, 2011: Mr. was examined by Dr. MD who gave Mr. the option of a surgical intervention. Mr. signed the consent for surgery. Dr. gave Mr. an injection into the right carpal tunnel region.

June 9, 2011: Mr. was examined by Dr. MD who noted that Mr. had a positive response to the carpal tunnel injection. He added a carpal tunnel release to his right wrist ECU tenolysis/6th dorsal compartment release vs. reconstruction procedure. Mr. signed a consent for surgery and is awaiting approval from workman's comp.

PATIENT CLINICAL HISTORY:

The claimant is employed as a xxxxx with xx.

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

The previous decisions are overturned. The claimant has undergone conservative treatment and still has tenderness over the ECU tendons. Based on the ODG the claimant meets the criteria for surgical intervention.

Per the ODG:

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. (Corso, 1997) (Shih, 2000) 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. (Shih, 2005)

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)