



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 5-24-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Wrist Arthroscopy with Triangular Fibrocartilage Complex (TFCC) - Scapholunate Ligament (SL) Debridement Versus Repair, Synovectomy and Carpal Tunnel Release between 4/1/11 and 5/31/11.

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

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the claimant was seen at on 9-3-10 under the direction of , PAC. The claimant reported that she moved around her cubicle wall to another cubicle to look at something and she tripped over a large camera bag, falling backwards to the left. She attempted to grab the cubicle wall with her right hand and missed, so all the weight landed on her left outstretched hand. Her pain is mainly in the left forearm > left shoulder > left elbow > left wrist with some decreased in range of motion with pain. On exam, there is no ecchymosis, no erythema, full range of motion with pain at the shoulder, elbow, forearm and wrist. X-rays showed no fracture. Assessment: POOSH injury: sprain of the wrist, forearm, elbow and shoulder (left). Plan: Hold off physical therapy as the claimant chooses to wait until follow up. The claimant was given a prescription for Anaprox and Darvocet. The claimant was advised to use ice/cool packs. The claimant was returned to work with restrictions.

Follow up at, MD., notes the claimant has decreased range of motion with pain. She denies paresthesias. On exam, the claimant has tenderness at the right and left with lateral movements. The movement of her index, long and ring fingers causes wrist pain that radiates to the forearm and spasms. Assessment: Outstretched left arm injury, sprain of the wrist, forearm and shoulder (left). Plan: OT, Biofreeze and ice, Naprelan and Amrix.

Medical records reflect the claimant began a course of physical therapy on 9-9-10. Physical therapy sessions on 9-14-10, 9-16-10, 9-30-10, 10-5-10, 10-7-10, 10-12-10, 10-21-10 and 10-26-10.

Follow up with Dr. on 9-15-10 notes the recommendation for ergonomic evaluation of her work station, MRI of the wrist, OT, Biofreeze, and Naprelan.

9-3-10 X-rays of the left forearm was normal.

9-20-10 MRI of the left wrist without contrast showed bone marrow contusions of the scaphoid and of the radial styloid. Partial perforation of the triangular fibrocartilage.

Follow up with Dr. on 9-23-10 notes the recommendation for ergonomic evaluation of her work station, OT, and Naprelan.

Follow up with Dr. on 10-7-10 notes the claimant has decreased range of motion with

persistent pain. The evaluator recommended the claimant continue with Naprelan and have an ergonomic evaluation of her work station.

10-13-10 MD., the claimant is a female. The patient presents today for an orthopaedic consultation regarding her left wrist Injury date was xx/xx/xx. The patient reports that they were injured while working. The patient was treated at. She states that she tripped over a camera bag and fell on her left hand. She injured her shoulder, arm, and wrist at the time of her fall. She says her shoulder and arm have healed, but her wrist has increasingly gotten worse. She reports that she has been experiencing numbness and tingling in all of her fingers and soreness in her ring finger. She says the pain will wake her up at night. She has had 7 physical therapy sessions at which seemed to help at first, but her pain has recently returned. She presents today in a wrist brace. She denies any past left wrist injuries or trauma. Her MRI is available today for evaluation. On exam, left wrist exam full composite fist and full extension. Effusion is not present. No shifting of the bones. No mid carpal instability Tenderness over the TFCC complex. Tinel's test is negative along the carpal tunnel. Impression: Joint pain, wrist (LT) wrist, triangular fibrocartilage complex (TFCC) tear (LT) wrist small, contusion, wrist (LT) wrist, scaphoid and radial styloid. Plan: he reviewed the patients MRI and explained that it does show an injury to the TFCC. It doesn't appear to be de stabilized. He explained it does show some bone bruising of the scaphoid and radial

styloid as well. He explained this can take 2-3 months to get better and he discussed giving this more time. If her pain does not subside we discussed going in arthroscopically to perform a TFCC debridement versus repair. In the meantime, would like for her to continue with the bracing, physical therapy and activity modification. He provided her with some samples of the Voltaren gel to begin using. As for work, she will remain on the same light duty restrictions given to her by.

Follow up with Dr. on 10-21-10 notes the claimant is provided with Naprelan and Voltaren cream. The evaluator continued to recommend ergonomic evaluation.

11-12-10 MD., the claimant states that for the past two weeks she has had pain at the end of all her fingertips, especially her middle finger even when she is wearing her brace. She notes she has numbness and tingling in her thumb, index, and middle fingers. She says she will have both in her ring and small fingers sporadically. She also has a throbbing sensation and clicking in her wrist. She says her symptoms have been keeping her up at night. On exam, carpal tunnel compression test is positive. The evaluator informed the claimant that she may have carpal tunnel syndrome that was exacerbated from her work related injury. He would like to order an EMG/NCV of the left upper extremity to confirm my suspicions. He briefly discussed surgical intervention depending on her EMG results. The claimant is to remain on the same work restrictions at this time and is to continue wearing her brace as often as possible. She is to return once the study is complete.

Follow up with Dr. on 11-18-10 notes the claimant reports pressure posteriorly occasionally painful at the left shoulder. The claimant has persistent tenderness especially with typing with right and left lateral rotation movement and flexion and extension si less painful at the left wrist. The evaluator recommended the claimant continue with Voltaren cream, Naprelan, wearing a wrist support.

1-25-11 EMG/NCS of the left upper extremity performed by MD., showed although there are clinical features of carpal tunnel syndrome, the electrodiagnostic studies performed

today do not reveal evidence of a median neuropathy.

Follow up with Dr. on 1-25-11 notes the claimant continues with painful left shoulder and left wrist. The claimant was provided with a prescription for Naprelan, Vicodin and Voltaren cream. The claimant was given a new wrist support and Biofreeze.

2-2-11 MD., the claimant returns today for a follow up of her left wrist and she is here today to receive her EMG results. She states that she continues to have the same pain and symptoms since her last visit, and notes that her pain has worsened some with the cold weather. The evaluator reviewed the patients EMG study and explained that it was normal. He reviewed her MRI once again today and explained it did show a partial tear of the TFCC. We discussed proceeding with a cortisone injection into the TFCC for diagnostic and therapeutic purposes which she has agreed to. She will remain on the same work restrictions of limited use of her left arm. He would like to see her back in 6 weeks for a follow up exam. The claimant was provided with an injection of Kenalog into the left TFCC.

2-10-11 Follow up with Dr. notes the claimant has persistent pain with poor grip strength and numbness and tingling and pain. The claimant has wrist pain and paresthesias of the 3rd, 4th fingers. The claimant was given a prescription for Vicodin and Voltaren cream. A new support wrist is recommended.

3-16-11 MD., the claimant returns today for follow-up of her left wrist. states she did not get any relief from the cortisone injection. She continues to wear the brace and limits her weight lifting. She continues to have popping/clicking in her wrist several times daily, which is painful and has been ongoing since her surgery date. On exam, she has positive Watsons test. Carpal tunnel compression test is positive. Tinel's test is positive along the carpal tunnel. The following surgical procedure is recommended to the patient: Left wrist arthroscopy with TFCC-SL debridement versus repair, synovectomy and carpal tunnel release.

Follow up with Dr. on 3-17-11 notes the claimant has been wearing her wrist support for many months without improvement. She has constant pain and is unable to perform the requirements neither at her job nor in her daily life. The claimant has persistent pain with poor grip strength and numbness and tingling and pain. She has paresthesias of the 3rd and 4th fingers. The claimant is given a prescription for Voltaren cream and Biofreeze.

3-22-11 UR performed by MD., provided a denial for Left Wrist Arthroscopy with Triangular Fibrocartilage Complex (TFCC) - Scapholunate Ligament (SL) Debridement Versus Repair, Synovectomy and Carpal Tunnel Release between 4/1/11 and 5/31/11. The evaluator reported that based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request for one left wrist arthroscopy with triangular fibrocartilage complex (TFCC) - scapholunate ligament (SL) debridement versus repair, synovectomy and carpal tunnel release is non-certified. Medical record dated 3/16/11 showed persistent left wrist pain. Current physical examination revealed positive Watson's, Tinel's, and carpal tunnel compression tests. MRI showed partial perforation of the triangular fibrocartilage. EDS was normal. Treatment has included TFCC steroid injection with no relief, medication, brace, and physical therapy. However, there is no documentation of at least 2 symptoms (Abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick sign

(shaking hand)), no current pregnancy, and positive electrodiagnostic testing. Therefore, the necessity of the request could not be established at this time.

3-29-11, MD., the claimant states her surgery has been denied by workers compensation and notes her pain has progressively worsened since Friday. She states she has a throbbing pain and she has numbness into her index, middle and ring fingers with pain into her middle finger, She states she is not able to hold small objects without increased pain. She states she still has pain over her dorsal wrist. She notes that she has been taking Vicodin for her pain, which is being prescribed to her by Dr.' office. On examination today the claimant continues to have pain which is consistent with carpal tunnel syndrome. We are awaiting authorization for her surgery, so in the meantime he was providing her with a prescription for Ultram to try for her pain. She is to remain on the same work restrictions at this time and he would like to see her back in 7-10 days after her surgery.

4-1-11 MD., provided a letter. She has a grossly positive Watson's sign with pain that is associated with instability produced by that maneuver. She also has an MRI which demonstrates a TFCC tear. Both of these are best evaluated with an arthroscopy and he felt that she would greatly benefit from this arthroscopic evaluation. It is clearly known that a scapholunate ligament injury will eventually lead to wrist arthritis and there is an opportunity at this juncture to address that if identified arthroscopically. An MRI will not clearly demonstrate that injury and the best evaluation for that again is arthroscopy. In regards to the carpal tunnel, the patient reports pain and paresthesia radiating into the median nerve distribution. This is clearly reproduced with a Durkin's carpal compression test. Carpal tunnel again is a clinical diagnosis, and given the fact that we are going to be in the operating room with an opportunity to address this condition for her as well, he felt that this would be a reasonable consideration. He would be happy to discuss this in person or over the phone with anybody that may have any further questions and he did sincerely hope that you reconsider her case and appreciate your care for her outcome.

4-8-11 UR performed by MD., reported that based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines referenced below, this request for left wrist Arthroscopy with Triangular Fibrocartilage Complex (TFCC) - Scapholunate Ligament (SL) Debridement versus Repair, Synovectomy and Carpal Tunnel Release is non-certified. The patient is a male who was injured on xx/xx/xx. Per the medical records, the patient continues to have popping/clicking in her wrist several times daily. The Physical examination of the left wrist reveals positive Watson's, Tinel's, and carpal tunnel compression tests. The MRI of the left wrist showed bone marrow contusions of the scaphoid and of the radial styloid. There was also a partial perforation of the triangular fibrocartilage. The electrodiagnostic studies performed do not reveal evidence of a median neuropathy. Although the patient does have symptoms consistent with a TFCC tear, there are normal EMG/NCV findings and the requested carpal tunnel release in this case is not indicated per guidelines. As such, certification for the procedures as submitted has not been established.

Follow up with Dr. on 4-28-11 notes the claimant has been wearing her wrist support for many months and is enduring increasing pain. She has constant pain and is able to perform limited requirements at her job also in her daily life. The claimant is placed on Tramadol, Voltaren cream, and Biofreeze.

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

BASED ON THE RECORDS PROVIDED, THE CLAIMANT HAS COMPLAINTS OF PAIN, POPPING AND CLICKING IN HER WRIST. SHE HAS A POSITIVE WATSON, TINEL'S AND CARPAL COMPRESSION TEST. HOWEVER, HER EMG/NCS SHOWS NO ELECTRODIAGNOSTIC EVIDENCE OF A MEDIAN NERVE PATHOLOGY. DOCUMENTATION PROVIDED DOES NOT DOCUMENT THAT THE CARPAL TUNNEL IS THE CAUSE OF HER PAIN. THE MRI ACTUALLY SHOWS BONE MARROW CONTUSIONS OF THE SCAPHOID AND OF THE RADIAL STYLOID AND PARTIAL PERFORATION OF THE TRIANGULAR FIBROCARILAGE. THEREFORE, THE REQUEST FOR LEFT WRIST ARTHROSCOPY WITH TRIANGULAR FIBROCARILAGE COMPLEX (TFCC) - SCAPHOLUNATE LIGAMENT (SL) DEBRIDEMENT VERSUS REPAIR, SYNOVECTOMY IS REASONABLE IN VIEW OF HER CONTINUED SYMPTOMS. HOWEVER, THE CARPAL TUNNEL RELEASE REQUEST IS NOT REASONABLE OR MEDICALLY INDICATED.

ODG-TWC, last update 2-21-11 Occupational Disorders of the Wrist – TFCC:

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)

ODG-TWC, last update 4-11-11 Occupational Disorders of the Wrist –Carpal

Tunnel Release: Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. Carpal tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. (Unfortunately, many CTR surgeries are performed on patients without a correct diagnosis of CTS, and these surgeries do not have successful outcomes.) Outcomes in workers' comp cases may not be as good as outcomes overall, but studies still support the benefits from surgery. Carpal tunnel syndrome may be treated initially with education, activity modification, medications and night splints before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits), but outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Surgical decompression of the median nerve usually has a high rate of long-term success in relieving symptoms, with many studies showing success in over 90% of patients where the diagnosis of CTS has been confirmed by electrodiagnostic testing. (Patients with the mildest symptoms display the

poorest post-surgery results, but in patients with moderate or severe CTS, the outcomes from surgery are better than splinting.) Carpal tunnel syndrome should be confirmed by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Any contributions to symptoms by cervical radiculopathy (double crush syndrome) will not be relieved by the surgery.

I. Severe CTS, requiring ALL of the following:

A. Symptoms/findings of severe CTS, requiring ALL of the following:

1. Muscle atrophy, severe weakness of thenar muscles
2. 2-point discrimination test > 6 mm

B. Positive electrodiagnostic testing

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II. Not severe CTS, requiring ALL of the following:

A. Symptoms (pain/numbness/paresthesia/impaired dexterity), requiring TWO of the following:

1. Abnormal Katz hand diagram scores
2. Nocturnal symptoms
3. Flick sign (shaking hand)

B. Findings by physical exam, requiring TWO of the following:

1. Compression test
2. Semmes-Weinstein monofilament test
3. Phalen sign
4. Tinel's sign
5. Decreased 2-point discrimination
6. Mild thenar weakness (thumb abduction)

C. Comorbidities: no current pregnancy

D. Initial conservative treatment, requiring THREE of the following:

1. Activity modification \geq 1 month
2. Night wrist splint \geq 1 month
3. Nonprescription analgesia (i.e., acetaminophen)
4. Home exercise training (provided by physician, healthcare provider or therapist)
5. Successful initial outcome from corticosteroid injection trial (optional).

See Injections. [Initial relief of symptoms can assist in confirmation of diagnosis and can be a good indicator for success of surgery if electrodiagnostic testing is not readily available.]

E. Positive electrodiagnostic testing [note that successful outcomes from injection trial or conservative treatment may affect test results] (Hagebeuk, 2004)

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)