

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: June/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

left ulnar shortening/wrist arthroscopy

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

M.D., Board Certified General Surgery
Fellowship: Orthopedic Hand and Upper Extremity Surgery

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

Official Disability Guidelines
Request for IRO 05/18/12
Utilization review determination 04/17/12
Utilization review determination 05/04/12
Physical therapy treatment record, 11/9/11
Clinical records Dr. 12/21/11-03/30/12
Radiographic report left wrist 12/21/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/x. She pulled a patient and felt pain in her left wrist. She is reported to have developed pain and swelling for two to three days after which she was evaluated at a local hospital. There was concern for possible tenosynovitis or wrist sprain. She was placed in a wrist splint and has not had any improvement. She saw Dr. on 12/21/11. She is reported to have previously undergone MRI, which did not show any significant ligamentous injury, just wrist edema. She has been undergoing occupational therapy with little help in regards to her prolonged pain. On physical examination she has mild swelling along the dorsal aspect of the wrist. There is positive tenderness to palpation throughout the wrist especially 4/5 at the dorsal interspace. She has a full composite fist. Sensation is intact. There is tenderness to palpation along the metacarpal bones. Radiographs of the left wrist show ulnar positive wrist with capitate cystic changes consistent with ulnar abutment. An outside MRI was reviewed and reported to show fluid at the radial ulnar joint and wrist edema. Dr. notes that the claimant's findings are congenital. However, it was probably aggravated while at work. The claimant was given a corticosteroid injection.

She was seen on 01/20/12, and reports feeling 75% better. Although she still is not able to lift heavy patients, she is able to work light duty and feels much better after injection. On examination there is no edema noted. DRUJ is stable. She has full flexion, extension, and pronosupination. She has some mild tenderness over the dorsal fourth and fifth interspace with pressure. Range of motion is not painful. On 03/02/12 the claimant was seen by Dr. She reports using her wrist for heavier things and that sometimes there is no other staff around to bathe the patient. She continues to use a removable brace. Dr. notes that the claimant's pain is returning and that it is too soon for reinjection. She indicates that definitive solution was ulnar shortening osteotomy.

The claimant was seen on 03/30/12. The claimant reports she has been doing normal duty since she was last seen. She reports having pain because she had to hold pressure on patient's groin where she works in her hospital. On physical examination she has mild edema present over the TFCC region and at the ulnar fovea. Her DRUJ is stable. She is tender at the dorsal fourth and fifth interspace. She has full pronosupination. She is recommended to undergo an ulnar shortening osteotomy and wrist arthroscopy with debridement of a TFCC tear. She received corticosteroid injection at this visit.

The initial review was performed by Dr. on 04/17/12 who non-certified the request noting that the left wrist MRI did not document any ligamentous injury. She has previously responded well to conservative treatment with steroid injections. He notes that her response to conservative treatment with oral pain medication, wrist brace, and home exercise was not documented and therefore medical necessity was not established.

An appeal request was reviewed by Dr. on 05/04/12 who non-certified the appeal request noting that the clinical record elaborates the claimant complaining of ongoing left wrist pain specifically on the ulnar side. He notes that the Official Disability Guidelines recommend an ulnar shortening provided the patient meets specific criteria to include imaging studies confirming TFCC involvement. He notes that there is a lack of information regarding the claimant's imaging studies confirming TFCC involvement and as such the request does not meet guideline recommendations and the previous denial was upheld

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

The submitted clinical records indicate that the claimant sustained an injury to her left wrist as a result of work related activity. The claimant has received conservative management consisting of oral medications and corticosteroid injection with benefit. The claimant or the record does not contain data regarding the claimant's response to other conservative modalities. Per Dr. notes the claimant had an essentially normal MRI of the wrist. There is no data to establish that the claimant has TFCC disruption/involvement and therefore the reviewer finds the request does not meet Official Disability Guidelines treatment recommendations for medical necessity. The reviewer finds no medical necessity for left ulnar shortening/wrist arthroscopy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)