

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/22/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right wrist hardware removal

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

Orthopedic 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

TWCC initial evaluation and progress reports 03/23/11-06/26/12

Operative report dated 03/25/11

Report of medical evaluation dated 10/13/11

Utilization review determination dated 06/25/12

Utilization review determination dated 07/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The records indicate he tripped on a forklift blade and fell backwards landing on his right hand. The claimant is status post ORIF right distal radius fracture and carpal tunnel release performed xx/xx/xx. Records indicate the claimant is determined to have reached maximum medical improvement as of 10/13/11 with 4% whole person impairment rating. The claimant was seen on 06/06/12 and stated he has noticed something dorsally by the lateral side which irritates him when he moves his fingers. He has no other complaints. Examination showed neurovascular exam intact. Positive fist is intact to 1 cm off the palm, but there is no neurovascular compromise with good capillary refill to all digits. Median nerve is intact. The DRUJ is stable without gross signs of instability, and remaining examination reveals no focal findings, except for screw on radial side is somewhat prominent now that you can feel just proximal to radial styloid. The claimant was recommended for hardware removal.

A request for right hardware removal was non-certified as medically necessary on 06/25/12. The reviewer noted it was unclear from information provided exactly where hardware resides. It is possible that there is prominent hardware on the dorsum of the wrist which could certainly predispose to additional rupture of the extensor tendons. If this is the case then hardware removal would be appropriate as long as complete fracture healing is documented. The record alone describe some palpable radial hardware but do not specifically describe pain and do not specifically describe the location of the hardware as to whether or not it would pose any danger to the overlying soft tissues. Absent additional clarification, medical necessity of hardware removal is not established.

A reconsideration request for right wrist hardware removal was non-certified as medically necessary on 07/03/12. The reviewer noted that ODG does not recommend routine removal of hardware implanted for fracture fixation, except for broken hardware or persistent pain after ruling out other causes of pain such as infection and nonunion. The claimant presents complaining of dorsal radial sided hardware irritatingly moving its fingers. Objective findings include a screw on the radial side that is somewhat prominent just proximal to the radial styloid. However, there is no clear documentation of persistent pain. In addition, no additional medical information was made available in the context of the appeal request. Furthermore there was no discussion as to what "indicated procedures" are considered beyond hardware removal. As such non-certification was recommended.

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

Based on the clinical data provided, the request for right wrist hardware removal is not supported as medically necessary. The claimant is noted to have sustained a distal radius fracture secondary to a fall. He underwent ORIF of right distal radius fracture, with open carpal tunnel release performed xx/xx/xx. Claimant was determined to have reached maximum medical improvement as of 10/13/11. There is a gap in treatment documentation from 11/15/11 to 06/06/12 at which time the claimant presented saying he has noticed something dorsally by the radial side which irritatingly as he moves his fingers. There were no other complaints. It is unclear or there is no documentation of treatment during the intervening period. No radiographs or other imaging studies were submitted documenting complete healing of the distal radius fracture, and no indication of hardware failure. It does not or there is no documentation that other causes of pain such as infection and non-union have been ruled out. No documentation was presented of persistent pain. Given the current clinical data, medical necessity is not established, and previous denials are upheld.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES