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NOTICE OF INDEPENDENT REVIEW DECISION

Apr/01/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right wrist injection

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

General Surgery, Fellowship trained 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)

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

Clinical notes 07/07/11-08/05/11

MRI right hand and wrist 08/04/11

Clinical notes 09/09/11-01/18/13

MRI right wrist 10/17/11

Operative report 12/13/11

Radiographs right forearm 02/22/12

Radiographs right forearm and wrist 03/26/12

Clinical notes 04/09/12 and 04/10/12

Radiographs chest 12/08/11

Prior reviews 01/21/13 and 02/07/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xxxxxx when he twisted his right hand. The patient was assessed with a possible lunotriquetral and scapholunate ligament tear as well as possible TFCC tear and underwent a right ulnar shortening osteotomy with debridement and chondroplasty of the ulnar pull of the proximal lunate with additional debridement of the TFCC on 12/13/11. Post-operatively, the patient had complaints of right wrist stiffness and there was indication that the patient was not compliant with a home exercise program. Post-operative radiographs of the right forearm and wrist in 03/12 identified multifocal osteoarthritis of the radiocarpal joint with a small amount of subcortical sclerosis and joint space narrowing of the radial lunate joint. The patient was recommended for injections of the right wrist in 10/12. The first dorsal compartment injection was performed on 11/07/12. Follow up on

12/12/12 stated that the patient had good relief with the initial injection, however. The patient continued to report pain over the dorsal radiocarpal articulation of the right wrist. Physical examination at this visit revealed tenderness to palpation over the radiolunate articulation with minimal distal radial ulnar joint tenderness. Moderate tenderness over the TFCC was noted. The patient was then recommended for intraarticular corticosteroid injection. Follow up on 12/21/12 documented the intraarticular injection of the right wrist. Follow up on 01/18/13 reported two weeks of relief with the first dorsal carpal injection. Physical examination was unchanged. The request for a right wrist injection was denied by utilization review on 01/21/13 as there was no documentation regarding substantial relief from initial injections which would be considered a therapeutic result. There was also a question on what area of the right wrist was actually injected. The request was again denied by utilization review on 02/07/13 as there was non-specific improvement documented regarding the injections and it was unclear what functional improvement the claimant achieved with prior injections.

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

The patient continued to report right wrist pain due to documented osteoarthritis within the radiocarpal joint. The patient has had two injections to date one being a first dorsal compartment injection and the second being what appears to be intraarticular wrist injection and right wrist injection. The most recent clinical note in 01/13 did not specifically identify any response from the second injection. The patient was only documented to have a two week response to the dorsal first dorsal compartment injection. As it is unclear what type of injection is now being recommended for the patient and there is no documentation regarding a clear therapeutic response to prior injections, further injections would not be supported by current evidence based guidelines. As such, it is the opinion of this reviewer that the prior denial is upheld and medical necessity is not established.

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