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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Wrist Scaphotrapezaiotrapezoidal Arthrodesis

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

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:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 01/22/13 – 04/11/13

Operative report dated 01/10/13

Left lower extremity venous Doppler exam completed on 01/13/13

Ultrasound of the left wrist dated 03/19/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his left wrist. The operative report dated 01/10/13 details the patient undergoing a right biceps tendon repair. The clinical note dated 01/22/13 details the patient presenting for a follow up regarding the biceps repair. The note does detail the patient having undergone a MRI of the left wrist in November of 2012 which revealed degenerative arthritic changes noted at the intercarpal articulations. This was noted to be most pronounced at the scaphoid, trapezoid, as well as the ulnar carpal and distal radial ulnar articulations. The clinical note dated 02/11/13 details the patient complaining of numbness at the tip of the thumb and elbow. Pain was elicited with extension. The note does detail the patient undergoing physical therapy; however, the patient was noted to present with a locked elbow. The clinical note dated 03/11/13 details the patient continuing with left wrist complaints. X-rays of the left wrist at that time revealed cystic changes throughout the wrist to include the DRUJ. The ultrasound dated 03/19/13 of the left wrist revealed no abnormalities. The clinical note dated 03/22/13 details the patient complaining of an increase in pain with pronation and supination at the left wrist.

The previous utilization review dated 05/02/13 for a left wrist arthrodesis resulted in a denial secondary to a lack of imaging studies confirming the patient's osteoarthritic findings.

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

The request for a left wrist scaphotrapezoiotrapezoidal arthrodesis is non-certified. The documentation submitted for review elaborates the patient complaining of left wrist pain. The Official Disability Guidelines recommend a wrist arthrodesis provided the patient meets specific criteria to include the patient is noted to have severe post traumatic arthritis at the wrist and the patient is noted to have completed 6 months of conservative therapy. No imaging studies were submitted confirming the patient's osteoarthritic findings. Additionally, it is unclear if the patient completed a full course of 6 months of conservative treatments. Given that no information was submitted regarding the patient's completion of all conservative measures addressing the left wrist complaints and taking into account that no imaging studies were submitted confirming the patient's osteoarthritic findings, this request does not meet guideline recommendations. As such, it is the opinion of the reviewer that the request for a left wrist scaphotrapezoiotrapezoidal arthrodesis is not recommended as medically necessary.

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)