

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Diagnostic Arthroscopy, with possible Triangular Fibrocartilage Repair, right wrist

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

Board Certified Orthopedic Surgeon

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her right wrist when she had a fall onto outstretched arms. The MRI of the right wrist dated xxxxx revealed no fracture or bone contusion. Edema was identified at the dorsal capsular joint as well as the mid-carpal joint. Minimal tenosynovitis was identified at the 2nd and 4th extensor compartments. A small degenerative signal was identified in the articular disc at the TFCC without a definitive full thickness tear. There is an indication of possible degeneration or a possible partial thickness tear. A possible tiny dorsal ganglion cyst was also revealed. The clinical note dated 04/10/13 indicates the patient complaining of 9/10 pain at the right wrist. The note does indicate the patient utilizing muscle relaxants as well as the application of ice, heat, and a brace. Upon exam, tenderness was identified at the TFCC and the proximal bones of the wrist. The clinical note dated 04/22/14 indicates the patient undergoing an injection at the right TFCC area. The patient continued with 7/10 pain. Pain was increased with various movements of the right wrist. The pain was located at the outer portion of the wrist. The patient had a difficult time making a full fist. The clinical note dated 05/16/14 indicates the patient receiving some relief following a Corticosteroid injection at the right TFCC. The patient rated the ongoing pain as 7-8/10. The note indicates the patient having completed a full course of conservative therapy as well as the ongoing use of oral anti-inflammatories. The clinical note dated 06/27/14 offers a clarification of the request to include a diagnostic arthroscopy at the right wrist to address the TFCC related complaints.

The utilization review dated 05/05/14 resulted in a denial for the arthroscopic repair of the TFCC as the MRI revealed degenerative changes only with no definitive evidence of a TFCC tear.

The utilization review dated 06/25/14 resulted in a denial as no definitive evidence was provided on imaging studies supporting a TFCC procedure.

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

The documentation indicates the patient complaining of ongoing right wrist pain despite a completion of a full course of conservative therapy as well as an injection. A diagnostic arthroscopy is indicated for patients who have an unclear clinical diagnosis despite significant findings revealed by a normal standard radiograph study and the patient has continued with persistent pain over a 12 week period. The submitted MRI revealed inconclusive findings involving the TFCC. However, no radiograph studies were submitted of the right wrist. Without radiograph studies confirming the patient's pathology, there is no evidence regarding the appropriateness of a diagnostic arthroscopy for the patient at this time. As such, it is the opinion of this reviewer that the request for a diagnostic arthroscopy with a possible TFCC repair at the right wrist is not recommended as medically necessary.

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