



## Medwork Independent Review

4095 136<sup>th</sup> Street  
Chippewa Falls, WI 54729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC*

**DATE OF REVIEW:** 8/26/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right wrist arthroscopy with TFCC tear repair.

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

Texas State Licensed MD Board 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 or not medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY:**

The claimant was noted to reportedly have been injured at the level of the right wrist (among other areas). In addition to an apparent associated head injury, there were reported knee injuries and bilateral wrist injuries. The claimant was noted to have associated speech issues that were felt to be related to the injury.

Clinical notes revealed that as of June 25, 2014 and prior that the claimant had persistent right wrist pain. Treatments to date were noted to have included medications such as oral NSAIDs along with topical agents. In addition, the claimant had undergone injections and treatment with altered activities along with splinting. The claimant had undergone pain management and had been considered for surgical intervention.

A prior MRI dated 02/07/2014 was of the right wrist. It was noted that, in addition to a volar wrist ganglion cyst, that there was a documented tear of the triangular fibrocartilage complex. The most recent clinical records as documented revealed in addition to the persistent pain that there was significant palpable tenderness to compression over the triangular fibrocartilage complex. Denial letters indicated that it would be appropriate for the results of a neurological workup to be assess in order to confirm whether or not the considered orthopedic surgery was reasonable and/or medically necessary.



## Medwork Independent Review

4095 136<sup>th</sup> Street  
Chippewa Falls, WI 54729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
www.medwork.org



### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The claimant has had a history of direct trauma to the affected right wrist. The persistent pain and objective clinical findings including tenderness and painful compression at the triangular fibrocartilage complex have been corroborated by the MRI, findings of a foreign triangular fibrocartilage complex. Extensive and reasonable non-operative treatments including restricted activities/racing along with medications, injections, and therapy have been well documented to have been tried and failed. The applicable ODG criteria for arthroscopic surgery and the criteria for surgery (including arthroscopic) repair of a torn triangular fibrocartilage complex/capital TFCC are well documented in the forearm, wrist, and hand chapter of the ODG guidelines. In this case, guidelines have been met due to the persistence, objective, findings, and failure of reasonable and extensive comprehensive non-operative treatments. Therefore, the considered procedure of right wrist arthroscopy with capital TFCC tear repair are reasonable and medically necessary as per the ODG criteria as referenced.

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

- ACOEM- AMERICAN 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)