

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Mar/07/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left wrist Arthroscopy and possible triangular fibrocartilage complex (TFCC) repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified 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. Medical necessity for Left wrist Arthroscopy and possible triangular fibrocartilage complex (TFCC) repair is not established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX and has been followed for complaints of left wrist pain. Prior treatment has included cortical steroid injections which resulted in 100% improvement of the patient's symptoms. Previous MRI studies of the left wrist from XX/XX/XX did note a peripheral tear in the TFCC without other abnormalities. The XX/XX/XX report noted that the patient had no long term relief following injections. The patient was occasionally using a wrist brace for the left wrist to provide comfort. No pertinent medications were noted at this evaluation. The patient's physical examination demonstrated mild tenderness over the left wrist at the ulnar forearm. No subluxation or instability was evident. Due to failure of non-operative management, the patient was recommended for possible TFCC repair. The repair of the TFCC of the left wrist was denied by utilization review on XX/XX/XX as no physical therapy records were provided for review and the records at this point did not reflect any current treatment. Furthermore, physical examination findings found no evidence of instability or subluxation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical records provided for review did note some mild tenderness over the left wrist stemming from an injury that is now almost XX years old. A recent conservative management outside of injection therapy was not documented in the records. As of XX/XX/XX the patient had no instability in the left wrist and exhibited some mild tenderness to palpation only. MRI studies of the left wrist are now more than one year old and only noted a tear in the periphery of the TFCC. Given the very minimal findings on physical examination, outdated imaging, and limited documentation regarding recent conservative management, it is this reviewer's opinion that the records would not meet guideline recommendations regarding the proposed surgical procedure. Therefore, medical necessity for Left wrist Arthroscopy and possible triangular fibrocartilage complex (TFCC) repair is not established at this point in time and the prior denials are upheld.

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)