

# US Decisions Inc.

An Independent Review Organization  
8760 A Research Blvd #512  
Austin, TX 78758  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: [manager@us-decisions.com](mailto:manager@us-decisions.com)

**DATE NOTICE SENT TO ALL PARTIES:** Apr/29/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Resection of Distal Ulna Right Wrist

**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.** It is the opinion this reviewer that the request for resection of the Resection of Distal Ulna Right Wrist is medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is an individual. On XX/XX/XX, the patient was seen with complaints of right wrist pain as well as loss of motion. She had been diagnosed previously as having a TFC tear and had arthroscopic debridement initially without relief of symptoms. She then underwent an ulnar shortening wafer procedure and she had dorsal dislocation of the ulna with pain and loss of motion in supination in particular. She also developed reflex sympathetic dystrophy being treated with a spinal cord stimulator. Examination of the wrist revealed 10 degrees of supination with significant discomfort. There were no signs of infection. There was a dorsal prominence of the ulna noted that could be reduced. Grip strength was limited to two pounds compared to 40 pounds on the contralateral side. X-rays of the wrist showed a dorsally dislocated ulna with respect to the radius. Surgery was recommended. On XX/XX/XX, a CT of the left wrist was obtained and was considered an unremarkable CT of the left wrist. On XX/XX/XX, a CT of the bilateral wrist showed a complete dislocation of the DRUJ of the right wrist with no change in positioning with limited range of motion present at the right wrist. Post-operative changes of the distal ulna were consistent with previous shortening.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** On XX/XX/XX, a utilization review report stated that the imaging provided for review indicated the patient had an unremarkable CT of the left wrist.

There were no objective findings of weakness and grip strength or limitation of motion on the physical examination. Therefore the request was non-supported.

The XX/XX/XX utilization review report non-certified the request for resection of the distal ulna right wrist and stated the CT provided was of the left wrist and not the involved right wrist. A peer to peer occurred, and the treating physician was advised to provide an addendum to the radiology report if it incorrectly described the images or provide the actual images showing the pathology by mail. Therefore at that time the request was non-certified.

Updated imaging shows a complete distal dislocation of the DRUJ of the right wrist. A physical examination shows tenderness and lack of rotation in the forearm with supination at approximately 10 degrees but with pain. There was no pronation of the forearm. The guidelines state that the procedure removes the distal articular surface of the ulna, relieving pain and improving supination and pronation. The procedure is recommended for those patients with limited activity.

It is the opinion this reviewer that the request for resection of the Resection of Distal Ulna Right Wrist is medically necessary and the prior denials are overturned.

**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)