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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 21, 2012

IRO CASE #: 43558

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP right wrist scope/possible TFCC repair scope versus open/possible debride ECU tendon 29846.

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

M.D., Board Certified in 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)

I have determined the requested OP right wrist scope/possible TFCC repair scope versus open/possible debride ECU tendon 29846 is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/28/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/01/12.
3. Notice of Assignment of Independent Review Organization dated 11/01/12.
4. Denial documentation.

5. Medical records dated 8/25/09.
6. Undated Preoperative Orders.
7. Medical records dated 8/27/12.
8. MRI right wrist dated 5/11/12.
9. Medical records dated 7/02/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx. On 8/25/09, the documentation noted that this resulted in a painful head/upper back, right wrist, and left elbow. The medical records noted that a prior wrist arthrogram revealed a triangular fibrocartilage tear, and an MRI revealed edema about the lunate bone and some partial tearing of the scaphoid lunate ligament. The patient was status post debridement on 1/05/09. On 5/11/12, an MRI of the right wrist showed a 4 mm central defect within the triangular fibrocartilage concerning for tear. The patient also had mild to moderate osteoarthritis of the radial carpal joint and subtle linear band of high signal within the extensor carpi ulnaris tendon that could represent focal tendinosis or partial thickness longitudinal tear. On 7/02/12, a physical therapy evaluation noted that the patient had reinjured his wrist due to repetitive strain and use of heavy equipment. Physical examination revealed mild swelling at the radial aspect of the right wrist over the triangular fibrocartilage complex. The patient was noted to have scars from the previous surgery at the same area. On 8/27/12, he reported gradually worsening wrist pain. The patient was noted to have a negative Watson's test and 5/5 strength. The note reported radiographs revealed partial distal ulna resection. The patient has requested coverage for OP right wrist scope/possible TFCC repair scope versus open/possible debride ECU tendon 29846.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that there was no clear documentation of a failure of additional conservative treatment, such as physical therapy and/or injections. On appeal, the URA noted that there is no documentation that the patient has undergone any conservative care consisting of steroid injections or physical therapy. Therefore, the Health Plan has denied coverage for the requested services.

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

Based upon Official Disability Guidelines and current medical evidence, the requested services are not medically indicated in this patient's case. In this patient's case, there is a lack of documentation regarding prior conservative care. The patient was noted to be doing well until a recent exacerbation of symptoms. There is no indication that the patient has failed to respond to recent conservative measures. The MRI study submitted for review indicated the patient had a 4 mm central defect within the triangular fibrocartilage concerning for tear. However, the report indicates that no prior exams were available for comparison. It is unclear if the radiologist was aware of the patient's previous surgery, as the 4 mm defect is likely from the previous procedure. Current evidence-based guidelines recommend conservative care prior to surgical intervention. All told, the patient does not meet Official Disability Guidelines criteria for the requested services, and the requested services are not medically necessary in this clinical setting.

Therefore**,** I have determined the requested OP right wrist scope/possible TFCC repair scope versus open/possible debride ECU tendon 29846 is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**