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| Case Number: | CM13-0044391 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 11/12/2009 |
| Decision Date: | 02/28/2014 | UR Denial Date: | 10/01/2013 |
| Priority: | Standard | Application Received: | 10/29/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland, North Carolina and Virginia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 58-year-old female with a reported date of injury on 11/12/2009 who complains of chronic left wrist pain. Previous surgeries have included arthroplasty of the left thumb basal joint, left shoulder surgery June 11, 2010, left wrist arthroscopy from 1/16/13, open scapholunate repair with FCR tendon transfer 2/9/13 and removal of K-wire 7/10/13. Despite her previous treatment and non-operative therapy, the patient continued to have severe chronic left wrist pain. On 9/17/2013, the patient was noted to have continued significant pain over the entire radial wrist exacerbated by heavy use. She has focal tenderness of the scapholunate joint and Watson's maneuver elicited severe pain and discomfort. She has continued with a protective brace and elevation. 'She has failed salvage operation for the left radial wrist pain.' Recommendation was made for left proximal row carpectomy and radial styloidectomy. 'The patient refused fusion as an option several times.' MRI dated 10/9/2012 documents degenerative cysts of the proximal hamate and capitate and absence of the trapezium. There is widening of the scapholunate space. There are particular degenerative changes involving the distal scaphoid, and trapezoid and proximal first metacarpal. The possibility of some segmental central column instability might be suggested. Following non-certification of left proximal row carpectomy and radial stylectomy, the patient continued to have severe left wrist pain. Follow-up from 12/3/13 notes that the patient still complains of severe pain and discomfort of the left wrist, exacerbated with any heavy strenuous use of the hand. She has exquisite tenderness across the entire wrist. Axial compression and radial ulnar deviation of the wrist significantly worsened the pain and discomfort. Recommendation was made for total wrist fusion with iliac crest bone graft. UR review dated 10/1/13 did not certify left proximal row carpectomy and radial styloidectomy, vascultherm4 with Cold/Heat therapy and compression, post-operative physical therapy (3x/week x 4 weeks) and splint dispensed at post-op visit. Rationale give was that based on Green's

Operative Hand Surgery, proximal row carpectomy is contraindicated given the findings of this patient's degenerative arthritis of the capitate as reported on MRI. This was 'discussed in detail with [REDACTED], and he agrees that given the MRI findings, the proposed surgery is not indicated at this time.' 'As the proposed surgery is not certified, the associated requests ... also not certified.'

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Decision for left proximal row carpectomy and radial styloidectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Arthrodesis, Fusion; Other Medical Treatment Guideline or Medical Evidence: Scott H. Kozin, Scott W. Wolfe, David P. Green, William C. Pederson, Robert N. Hotchkiss, Green's Operat

Decision rationale: The patient is a 58-year-old female with clear severe chronic pain that has failed both non-operative and operative management. From CA MTUS ACOEM, p. 270 indications for surgical treatment/consultation are given: Referral for hand surgery consultation may be indicated for patients who: - Have red flags of a serious nature - Fail to respond to conservative management, including worksite modifications - Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention The patient clearly satisfies requirements for possible surgical intervention. The pain has persisted despite non-operative and other operative intervention. The surgeon has stated that a salvage operation is necessary. This determination is based on whether a functional row carpectomy and radial styloidectomy is medically necessary. As documented in the utilization review, Green's Operative Hand Surgery provides analysis of this procedure. From Chapter 19, 'Proximal row carpectomy is a motion-preserving salvage procedure for wrist arthritis that may be performed arthroscopically.' Contraindications: 'A prerequisite for this procedure is a preserved lunate fossa and good remaining cartilage on the proximal capitate.' From Sammer and Shen with respect to wrist surgery, 'Definitive surgical treatment, however, requires either a scaphoidectomy four-corner fusion or a proximal row carpectomy. The decision of which operation to perform depends on the stage of the arthritis and on other considerations. In patients with stage III scapholunate advanced collapse wrist, scaphoidectomy and four-corner fusion is the only option. However, if the midcarpal joint is preserved (stages I and II), either proximal row carpectomy or four-corner fusion can be performed.' I would agree with the utilization review that based on the MRI results from 10/9/12 in which there were degenerative cysts of the capitate as well as other degenerative changes, proximal row carpectomy would not be appropriate. From ODG with respect to wrist fusion, it is 'recommended in severe posttraumatic arthritis of the wrist or thumb or digit after 6 months of conservative therapy. Total wrist arthrodesis is regarded as the most predictable way to relieve the pain of posttraumatic wrist arthritis. Total wrist fusion diminishes pain, but wrist function is sacrificed. Patients may have functional limitations interfering with lifestyle, and total fusion does not always result in

complete pain relief. Arthrodesis (fusion) provides a pain-free stable joint with a sacrifice of motion. It may be indicated in young patients in whom heavy loading is likely; in joints with a fixed, painful deformity, instability, or loss of motor; and in the salvage of failed implant arthroplasty.' Again, based on the severity of the degenerative changes of the wrist, proximal row carpectomy with styloidectomy would not be medically nec

Decision for VacuTherm4 with cold/heat therapy and compression: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Arthrodesis, Fusion; Other Medical Treatment Guideline or Medical Evidence: Scott H. Kozin, Scott W. Wolfe, David P. Green, William C. Pederson, Robert N. Hotchkiss, Green's Opera

Decision rationale: Based on non-certification of the procedure of proximal row carpectomy and radial styloidectomy, cold/heat therapy would not be medically necessary.

Decision for post-operative physical therapy, quantity 12 (3 times per week for 4 weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Arthrodesis, Fusion; Other Medical Treatment Guideline or Medical Evidence: Scott H. Kozin, Scott W. Wolfe, David P. Green, William C. Pederson, Robert N. Hotchkiss, Green's Opera

Decision rationale: Based on non-certification of the proximal row carpectomy and radial styloidectomy, postoperative physical therapy would not be medically necessary.

Decision for splint: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Arthrodesis, Fusion; Other Medical Treatment Guideline or Medical Evidence: Scott H. Kozin, Scott W. Wolfe, David P. Green, William C. Pederson, Robert N. Hotchkiss, Green's Opera

Decision rationale: Based on non-certification of the proximal row carpectomy and radial styloidectomy, a postoperative splint would not be medically necessary.