

Case Number:	CM14-0001264		
Date Assigned:	01/22/2014	Date of Injury:	12/19/2013
Decision Date:	03/25/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/03/2014

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 Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Oregon. 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:

This male sustained a right arm injury on 4/26/12. He sustained a distal radius fracture and was treated with ORIF on 5/2/12. He now complains of difficulty with composite fist flexion, weakness and pain with forearm rotation as well as numbness and tingling in his right hand fingers. X-rays show a healed fracture with an ulnar positive variance, incongruity of the distal radial ulnar joint and a DISI deformity of the carpal bones. Nerve conduction testing shows mild bilateral carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hardware removal: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Hardware Removal

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Hardware Removal

Decision rationale: The patient has hardware from his distal radius fracture repair. The records do not document any issues due to the hardware. The hardware is not described as contributing

to his DRUJ pain or to the carpal tunnel syndrome. According to the ODG guidelines, Forearm, Wrist and Hand, "Hardware removal is not recommended. Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection. Recommend removal of hardware when fractures are not involved, the pins are stabilizing a joint while a ligament or tendon repair is healing and they must be removed so that the joint can resume function, for example, a pin in the DIP joint of a finger to stabilize while an extensor tendon is healing in place or in the wrist to stabilize carpal bones while a scapholunate or other ligament reconstruction is healing. Although hardware removal is commonly done, it should not be considered a routine procedure. The decision to remove hardware has significant economic implications, including the costs of the procedure as well as possible work time lost for postoperative recovery, and implant removal may be challenging and lead to complications, such as neurovascular injury, refracture, or recurrence of deformity. Current literature does not support the routine removal of implants to protect against allergy, carcinogenesis, or metal detection. (Busam, 2006) Despite advances in metallurgy, fatigue failure of hardware is common when a fracture fails to heal. Revision procedures can be difficult, usually requiring removal of intact or broken hardware. (Hak, 2008) Following fracture healing, improvement in pain relief and function can be expected after removal of hardware in patients with persistent pain in the region of implanted hardware, after ruling out other causes of pain such as infection and nonunion."

Right carpal tunnel release: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery--Carpal Tunnel Release

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The carpal tunnel release is medically necessary. According to the ACOEM guidelines, page 270, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS, patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken." This patient has significant symptoms of carpal tunnel syndrome, an exam consistent with carpal tunnel syndrome and positive electrodiagnostic studies for median nerve compression. Per the ACOEM guidelines, carpal tunnel release is medically necessary.

Right distal ulna resection: Overturned

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 Green's Operative Hand Surgery, Chapter 16

Decision rationale: According to ACOEM Chapter 11, page 270, 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 This patient has ulnar impaction and a disrupted distal radial-ulnar joint. Shortening the ulna will tighten the DRUJ, change the impact point, and unload the ulnar side of the wrist. According to Green's Operative Hand Surgery, Chapter 16, "Acquired ulnar-positive variance is a known risk factor for ulnar impaction syndrome because of the associated increase in ulnocarpal loading. A 2.5-mm increase in ulnar variance increased ulnocarpal loading by 42% in a cadaveric study. In a similar study, changing the tilt of the distal radius from normal to 40 degrees of dorsal tilt increased the ulnar load from 21% to 65%. Common causes of acquired positive variance include radial shortening from a distal radius fracture, Essex-Lopresti injury, and acute or chronic physical injury." This patient has increased loading of the ulnar side of his wrist, and ulnar shortening will decrease force transmission and alleviate pain.

DME-scope: Overturned

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 Green's Operative Hand Surgery, Chapter 16

Decision rationale: According to ACOEM Chapter 11, page 270, 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 According to Green's Operative Hand Surgery, Chapter 16, arthroscopic diagnosis and debridement is the standard of care for the management of TFCC tears. This patient likely has a TFCC tear from chronic ulnar impaction.

Postoperative occupational therapy 2 x 6 weeks for right distal ulna: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): 22.

Decision rationale: postoperative occupational therapy 2 x 6 weeks for right distal ulna