

<b>Case Number:</b>	CM14-0152801		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	09/08/2012
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopaedic Surgery, and is licensed to practice in California. 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 expert 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 35-year-old female sustained an industrial injury on 9/8/12. The mechanism of injury was not documented. The 11/11/13 bilateral upper extremity EMG/NCV was reported within normal limits. The 5/12/14 right wrist MR arthrogram impression documented no communicating tear in the scapholunate, lunotriquetral, triquetral-hamate, or scaphotrapezium ligaments. The post-arthrogram MRI impression documented a partial tear of the scapholunate ligament. There was extensive bone marrow edema in the right lunate compatible with a trabecular bone injury. Thinning of the articular cartilage at the ulnar/proximal aspect of the lunate was documented with associated subchondral cystic changes. There was flattening of the right median nerve in the carpal tunnel with findings suggestive of right carpal tunnel syndrome. The 8/21/14 treating physician report cited worsening pain on the dorsal/ulnar aspect of the right wrist and bilateral thumb numbness. Physical exam documented pain with passive and active range of motion right wrist, especially in passive extension and ulnar deviation. There was slight tenderness at the dorsal/ulnar aspect of the right wrist. Grip strength, two-point pinch, and three-point pinch were decreased 20-25% on the left. Key pinch was symmetrical. MRI and MR arthrogram findings were reviewed. The diagnosis was rule-out ulnar impaction syndrome. Authorization was requested for arthroscopic assisted evaluation of the radio-carpal joint and mid carpal joint with synovectomy and possible TFCC (Triangular Fibrocartilage Complex) debridement, if indicated, and ulnar shortening osteotomy, if indicated by arthroscopy. The 9/10/14 utilization review modified the request for right wrist arthroscopic evaluation and complete synovectomy, arthroscopic assisted right triangular fibrocartilage complex Repair or debridement, as indicated, and right ulnar shortening osteotomy, use of fluoroscopy to a right wrist arthroscopic evaluation and complete synovectomy only as there was no evidence of a TFCC tear. The handwritten

appeal note stated that MRI imaging cannot always detect these injuries. If seen at surgery, they must be repaired.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right wrist arthroscopic evaluation and complete synovectomy, arthroscopic assisted right triangular fibrocartilage complex Repair or debridement, as indicated, and right ulnar shortening osteotomy, use of fluoroscopy:** Overturned

**Claims Administrator 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: Forearm, wrist, & hand Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 80-81.

**Decision rationale:** The Revised ACOEM Hand, Wrist and Forearm Guidelines state that diagnostic arthroscopy is often combined with surgical repair. Guidelines recommend surgical repair (arthroscopic or open) of the triangular fibrocartilage complex (TFCC) for patients with instability, concomitant fractures, or symptoms that persist without trending towards resolution despite non-operative treatment and the passage of approximately 3 to 6 weeks. Ulna shortening and wafer procedures are recommended for select cases of chronic TFCC tears and chondromalacia with or without lunotriquetral ligament disruption for which non-surgical treatment is unsuccessful and there is a demonstrable ulna positive variance. Guideline criteria have been met. The 9/10/14 utilization review modified this request and approved a right wrist arthroscopic evaluation and complete synovectomy. The request for possible TFCC debridement and ulnar shortening osteotomy was denied. The surgeon has requested authorization to perform these procedures if operative findings dictate. He stated that MR imaging cannot always detect these tears and occult findings at arthroscopy will needed to be addressed. Occult ligament tears, incomplete and MRI-negative, are often confirmed at time of arthroscopic surgery. Therefore, request for the following: Right wrist arthroscopic evaluation and complete synovectomy, arthroscopic assisted right triangular fibrocartilage complex Repair or debridement, as indicated, and right ulnar shortening osteotomy, use of fluoroscopy; is medically necessary.

**X-ray; right wrist 2 views:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, & Hand Chapter Radiographs (X-rays)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 78-79.

**Decision rationale:** The revised ACOEM Hand, Wrist and Forearm Guidelines recommend x-rays to diagnose triangular fibrocartilage complex (TFCC) tears and/or to rule-out other sources

of wrist pain. Obtaining x-rays once is generally sufficient. X-rays may assist particularly in ruling out other potential sources of wrist pain. They are also indicated for those who fail to improve or have other symptoms suggesting consideration of other potential diagnoses. X-rays also assist with analysis for evidence of other conditions such as osteoarthritis and positive ulnar variance. Guideline criteria have been met. This request is reasonable to rule-out other sources of pain and identify positive ulnar variance. Therefore, request for X-ray; right wrist 2 views are medically necessary.

**X-ray right forearm, 2 views:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, & Hand Chapter Radiographs (X-rays)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 78-79.

**Decision rationale:** The revised ACOEM Hand, Wrist and Forearm Guidelines recommend x-rays to diagnose triangular fibrocartilage complex (TFCC) tears and/or to rule-out other sources of wrist pain. Obtaining x-rays once is generally sufficient. X-rays may assist particularly in ruling out other potential sources of wrist pain. They are also indicated for those who fail to improve or have other symptoms suggesting consideration of other potential diagnoses. X-rays also assist with analysis for evidence of other conditions such as osteoarthritis and positive ulnar variance. Guideline criteria have been met. This request is reasonable to rule-out other sources of pain and identify positive ulnar variance. Therefore, request for X-ray right forearm, 2 views is medically necessary.

**PA Assistant:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Milliman Care Guidelines <http://www.facs.org/ahp/pubs/2002physasstsurg.pdf>

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT Codes 29845, 25320 and 25360, there is a "2" in the assistant surgeon column for each procedure. Therefore, based on the stated guideline and the complexity of the procedure, the request for PA Assistant is medically necessary.

