

Case Number:	CM14-0049500		
Date Assigned:	07/07/2014	Date of Injury:	04/19/2013
Decision Date:	08/27/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/17/2014

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 Occupational Medicine, 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:

Patient is a 45-year-old male who has submitted a claim for right wrist fracture associated with an industrial injury date of 04/19/2013. Medical records from 2013 to 2014 were reviewed. Patient complained of right wrist pain. Physical examination showed focal tenderness at the radio carpal joint of the right wrist with limited motion secondary to pain. CT scan of the right wrist from 02/18/2014 demonstrated incompetent scapholunate ligament, with associated SLAC wrist and status post ORIF comminuted distal radius fracture. Treatment to date has included ORIF of the right wrist and removal of deep pins from scapholunate joint of the right wrist x 2 (09/17/2013). Utilization review from 03/20/2014 denied the request for proximal row carpectomy, styloidectomy with regional block under general anesthesia because of limited significant objective findings and exceptional factors in the right wrist to support the request. There was also limited documentation of conservative management provided. Without approval of the requested surgery, all the other requests such as post-operative Physical therapy for the right wrist X 12, Pre-op medical clearance (CBC, Electrolytes, UA, PT, PTT), and Pre-Operative medical clearance for chest x-ray were likewise not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Proximal row carpectomy, styloidectomy with regional block under general anesthesia:
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)-TWC Forearm, Wrist and Hand Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Proximal Row Carpectomy, Wheeler's Textbook of Orthopedics.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, The Wheeler's Textbook of Orthopedics was used instead. It states that Proximal Row Carpectomy is indicated in advanced scapholunate dissociation (see SLAC), dorsiflexion instability, nonunion of scaphoid (w/ carpal instability), failed silicone lunate implant arthroplasty, and Kienbock's disease. On proximal row carpectomy for SLAC, it states that advantages are that it is technically easy, and often allows better preservation of strength and motion, as compared to limited carpal arthrodesis; patients can expect over 60% of normal ROM as compared to opposite wrist and over 90% of normal grip strength; this compares to four corner fusion, in which patients can expect less than 50% ROM and about 75% grip strength; relatively contra-indicated w/ capitulunate arthrosis. A limitation of radial deviation may be a common postoperative finding; hence, a radial styloidectomy should be considered if impingement is observed at the time of surgery. However, in most cases, a radial styloidectomy will probably not be necessary. In this case, the documented rationale for the requested surgery was due to severe lunatohamate grade IV chondromalacia and degenerative changes at the joint space. A carpectomy was needed to obviate the incompetent scapholunate ligament and radioscaphoid arthrosis. On the other hand, styloidectomy was requested to improve radial deviation following the surgery. However, there was no comprehensive documentation concerning subjective complaints, restrictions in activities of daily living, physical examination, and prior conservative management provided that may support the request. The medical necessity cannot be established due to insufficient information. Therefore, the request for proximal row carpectomy, styloidectomy with regional block under general anesthesia is not medically necessary.

Post-operative Physical therapy for the right wrist X 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for proximal row carpectomy and styloidectomy has been deemed not medically necessary; therefore, all of the associated services, such as this request for Post-operative Physical therapy for the right wrist X 12 is likewise not medically necessary.

Pre-op medical clearance (CBC, Electrolytes, UA, PT, PTT): 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)-TWC Pre-operative testing.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for proximal row carpectomy and styloidectomy has been deemed not medically necessary; therefore, all of the associated services, such as this request for Pre-op medical clearance (CBC, Electrolytes, UA, PT, PTT) is likewise not medically necessary.

Pre-operative medical clearance for chest x-ray: 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)-TWC: Pre-operative testing.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for proximal row carpectomy and styloidectomy has been deemed not medically necessary; therefore, all of the associated services, such as this request for Pre-operative medical clearance for chest x-ray is likewise not medically necessary.