

Case Number:	CM14-0061533		
Date Assigned:	07/09/2014	Date of Injury:	12/16/2013
Decision Date:	08/08/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/02/2014

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 Plastic and Reconstructive Surgery, and is licensed to practice in Maryland, Virginia, North Carolina. 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:

The patient is a 38-year-old male with a reported date of injury on 12/16/13 who requested right wrist arthroscopy and complete synovectomy, open repair and use of fluourosocopy, X-rays of the right wrist and long arm splint. Documentation from 12/18/13 notes the patient had fallen on outstretched hands on 12/16/13. Examination noted slight swelling of the right ulnar wrist and 'exquisite tenderness to palpation over the fovea insertion and at the dorsal ulnar aspect of the wrist.' Range of motion is decreased of the right wrist. Multiple provocative tests are positive. Assessment is right ulnar-sided wrist pain with a high suspicion of a TFCC tear. He was splinted and given medication prescriptions and plan for an MRI. Work restrictions were recommended. Further documentation noted in the utilization review, notes follow-up of right ulnar wrist pain. This has persisted with no improvement despite steroid injection, splinting, and medication. Examination continues to show right ulnar wrist pain with decreased strength of the right wrist. MRI from 1/24/14 notes partial tear of the right TFCC. Utilization review dated 4/17/14 did not certify the requested procedures. Reasoning given was that the patient had not exhausted all forms of conservative care. He had not undergone formal physical therapy. However, he had undergone use of medications, splinting and steroid injection.

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: 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 Other Medical Treatment Guideline or Medical Evidence: Mark D. Miller, and Stephen R. Thompson. DeLee & Drez's Orthopaedic Sports Medicine, Fourth Edition Copyright 2015, 2010, 2003, 1994 by Saunders. 'Triangular Fibrocartilage Complex Injuries' Chapter 76, 875-883.e1.

Decision rationale: The patient is well documented to have persistent right ulnar-sided wrist pain consistent with a partial TFCC tear that has progressed to loss of strength. Although the reviewer has stated that one should exhaust all forms of conservative care prior to surgery, the patient has undergone significant conservative management. He has undergone medication treatment, splinting, worksite modification and a steroid injection. His MRI evaluation is consistent with his pathology. He is well documented to have continued pain and loss of strength. Formal physical therapy would not be expected to improve the patient's condition given the persistence of pain despite splinting, worksite modification and injection. From Chapter 76 of DeLee & Drez's Orthopaedic Sports Medicine, 'Triangular Fibrocartilage Complex Injuries', 'Conservative therapy begins with wrist immobilization, either with a cast or removable splint, along with activity modification and use of ice and non-steroidal anti-inflammatory drugs as needed to control symptoms.' 'Reports in the literature are scarce regarding the outcomes of conservative treatment of acute TFCC injuries. One study showed that symptoms of 57% of patients immobilized with a short arm cast or wrist splint improved over 1 month. Many surgeons, including the authors, would tend to recommend a course of conservative therapy for at least 4 to 6 weeks, but no longer than 3 months, prior to a discussion of surgical intervention.' Thus, the patient is documented to have undergone appropriate conservative management. An arthroscopic evaluation in preparation for possible TFCC repair or reconstruction is medically necessary and consistent with ODG as outlined below and the reference provided. ACOEM does not specifically address this but as documented in the utilization review: From 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 as stated above, the patient has failed to respond to conservative management (although not formal hand therapy) including worksite modifications, medication, splinting and injection. Intervention to address a TFCC tear is well-recognized treatment and shown to be beneficial. Thus, arthroscopic evaluation to confirm the TFCC tear is consistent with medically necessary criteria as outlined by ACOEM and confirmed by ODG as noted below. Synovectomy is part of this evaluation and treatment. With respect to diagnostic arthroscopy, from ODG: 'Recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. This study assessed the role of diagnostic arthroscopy following a wrist injury in patients with normal standard radiographs, an unclear clinical diagnosis and persistent severe pain at 4 to 12 weeks. Patients with marked persistent post-traumatic symptoms despite conservative management are likely to have sustained ligament injuries despite normal radiographs. It is recommended that under these circumstances an arthroscopy may be carried out as soon as 4 weeks if the patient and surgeon wish to acutely repair significant ligament injuries. (Adolfsson,

2004)' The patient has persistent pain that has failed conservative management. The arthroscopy is used to definitively diagnose the TFCC tear in preparation for repair/reconstruction. Thus, it is medically necessary.

Right wrist open repair and use of fluroscopy: 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 Official Disability Guidelines (ODG) Forearm, Wrist and Hand, TFCC reconstruction.

Decision rationale: As stated above, the patient has persistent ulnar sided right wrist pain that has failed conservative measures and has progressed to loss of strength. His clinical picture is consistent with a TFCC tear that could be addressed by arthroscopic confirmation, followed by open repair. From ODG, with respect to TFCC reconstruction, Recommended as an option. Arthroscopic repair of peripheral tears of the triangular fibrocartilage complex (TFCC) is a satisfactory method of repairing these injuries. Injuries to the triangular fibrocartilage complex are a cause of ulnar-sided wrist pain. The TFC is a complex structure that involves the central fibrocartilage articular disc, merging with the volar edge of the ulnocarpal ligaments and, at its dorsal edge, with the floors of the extensor carpi ulnaris and extensor digiti minimi. (Corso, 1997) (Shih, 2000) Triangular fibrocartilage complex (TFCC) tear reconstruction with partial extensor carpi ulnaris tendon combined with or without ulnar shortening procedure is an effective method for post-traumatic chronic TFCC tears with distal radioulnar joint (DRUJ) instability suggested by this study. (Shih, 2005). Fluoroscopy may be necessary for intra-operative guidance to complete TFCC repairs and/or reconstruction. ACOEM does not specifically address TFCC reconstruction but provides guidelines to warrant surgical treatment. From 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. The patient has progression of his symptoms despite conservative measures. TFCC reconstruction or repair can adequately assess this. The reviewer states that the patient has undergone conservative management, but just not formal physical therapy. As stated above, based on the medical record the patient has adequately undergone a reasonable course of non-operative management and further physical therapy would not be expected to change his clinical condition.

X-rays of the right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, Forearm, wrist and hand, Corpus Christi (TX) & Official Disability Guidelines, Forearm, Wrist & Hand Chapter.

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, Radiography.

Decision rationale: From ODG, radiography is indicated for acute hand or wrist trauma. The patient had previously undergone radiography of the wrist followed by MRI examination. Arthroscopy will be used to definitively diagnose the TFCC tear and other pathology. It is not exactly clear from the medical record, the reason for additional radiography. Further detail would need to be provided as to the exact reason. If this is for postoperative evaluation or to evaluate the success/alignment of any intervention, then this needs to be adequately reasoned in the medical record. Thus, wrist radiography is not deemed medically necessary based on the medical records provided for review.

Long arm splint: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 264, 272. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand Chapter, Splints; Arm sling.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Mark D. Miller, and Stephen R. Thompson. DeLee & Drez's Orthopaedic Sports Medicine , Fourth Edition Copyright 2015, 2010, 2003, 1994 by Saunders. 'Triangular Fibrocartilage Complex Injuries' Chapter 76, 875-883.e1.

Decision rationale: Given the primary procedure is considered medically necessary, splinting following surgery is medically necessary as well as there can be significant swelling and pain following surgery. From ACOEM, Forearm, hand and wrist, Table 11-7, rest and immobilization is an option for post-operative conditions in managing wrist injuries. This includes the use of a splint. Specifically, with respect to TFCC repairs from DeLee & Drez's Orthopaedic Sports Medicine 'Patients who have undergone a simple arthroscopic debridement often wear a splint for 2 to 4 weeks after surgery for wound protection and comfort before undertaking progressive motion recovery.' Thus, splinting would be considered medically necessary.