

Case Number:	CM15-0107483		
Date Assigned:	06/11/2015	Date of Injury:	12/02/2009
Decision Date:	07/13/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic Surgery

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 injured worker is a 60 year old female, who sustained an industrial injury on 12/02/2009. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having pain to the joint involving the forearm, other joint derangement not elsewhere classified involving the forearm, pain in the limb, osteoarthritis localized, primary involving the hand, lesion of the ulnar nerve, and carpal tunnel syndrome. Treatment and diagnostic studies to date has included status post ligament reconstruction to the right wrist, status post right cubital and carpal tunnel releases, electromyogram with nerve conduction velocity, status post right shoulder surgery, and right wrist x-rays. In a progress note dated 05/11/2015 the treating physician reports complaints of persistent, increase in pain to the right wrist with an increase of swelling, along with difficulty with sleeping, inability to eat secondary to pain, and irritability. Examination reveals tenderness to the right dorsal and volar wrist, an increase in swelling to the volar wrist, and decreased range of motion to the right wrist. There is evidence of carpal instability. Previous X-rays noted a 3.8 mm scapholunate interval on PA view and scapholunate angle of 60 degrees on lateral view. Joint spaces are preserved. The treating physician requested possible right proximal row carpectomy, possible right scaphoid excision, and/or possible mid carpal arthrodesis with scaphoid bone graft outpatient for persistent wrist pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible right proximal row carpectomy, possible right scaphoid excision, possible mid carpal arthrodesis with scaphoid bone graft outpatient within MPN: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Book Chapter. Carpal Instability, Marc Garcia-Elias, Green's Operative Hand Surgery, chapter 15, 465-522.

Decision rationale: The patient is a 60 year old female with chronic severe right wrist pain that has affected her hand function significantly. This has failed previous surgical treatment twice as well as other conservative management including a history of physical therapy, splinting, activity modification and medications/analgesia. Based on the entirety of the medical record, the patient appears to have chronic scapholunate dissociation that has failed 2 previous attempts at stabilizing the wrist with scapholunate ligament treatment. This has created a carpal instability that is likely the cause of her severe, chronic pain. It is unlikely any surgical treatment would be beneficial other than a salvage procedure as requested by the surgeon. The two procedures requested are used in carpal instability as outlined in Green's Operative Hand Surgery: Scaphoidectomy plus Midcarpal Fusion-Popularized by Watson and coworkers, the SLAC procedure (scaphoid excision plus a capitate-lunate-triquetrum-hamate fusion, also known as four-corner fusion) has gained an excellent reputation for the treatment of chronic SLD. For the operation to be successful, good articular cartilage at the radiolunate level is required. A frequent complication is the development of dorsal impingement between the dorsal edge of the radius and the capitate. An important step to avoid this is to correct the DISI deformity fully before stabilizing the midcarpal joint. Low-profile circular plates have been designed to be countersunk below the dorsal intersection of the four bones so that radial impingement is avoided. In selected cases, fusion is limited to the lunocapitate joint, particularly in ulnar-plus wrists in which an excessively rigid triquetrum could precipitate ulnocarpal abutment. Another alternative, which is particularly useful in cases with chronic combined scapholunate and lunate triquetrum instability (perilunate instability), is to excise the scaphoid and triquetrum before fusing the lunocapitate joint. Proximal Row Carpectomy-Proximal row carpectomy is a salvage operation that creates a creating a neoarticulation between the capitate and the lunate fossa of the radius after proximal carpectomy. In most series, the procedure has proved to be good in terms of pain relief and restoration of functional wrist motion and grip strength, with high overall patient satisfaction. In mechanical terms, this operation converts a complex composite articulation into a single ball-and-socket joint with nonmatching articular surfaces. The wrist can adjust to such an incongruity only if there is good articular cartilage on the proximal pole of the capitate and in the lunate fossa of the radius. Compared with the SLAC procedure, this technique avoids long immobilization and the risk of nonunion. It has the added advantage of being convertible to a wrist arthrodesis or arthroplasty if at a later date it evolves into a painful osteoarthritis. Long-term radiocapitate degeneration, although often asymptomatic, is present in about one third of patients with more than 10 years of follow-up. The decision between the two procedures can be made intra-operatively, as planned by the requesting surgeon. As the patient has failed reasonable treatment and previous surgical attempts at correction of a scapholunate

injury, a salvage operation appears indicated at this time. The UR stated that patient had had 2 previous wrist surgeries without benefit. Based on the type of surgery that was performed, this actually favors a salvage operation at this point. In addition, the UR stated that there is no documentation of advanced scapholunate dissociation or dorsiflexion instability. However, based on the entirety of the medical record and the examination detail, the patient has carpal instability likely related to a chronic scapholunate dissociation. Therefore, as no other alternative appears reasonable or was offered by the UR, an attempt at a salvage procedure for relief of chronic pain and improvement in function is medically necessary.