

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 06/11/2010

IRO CASE #:

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Orthopaedic Surgery Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient right wrist/forearm fusion with right iliac crest bone graft

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-08-10 Medical report from Dr.
- o 04-23-10 Medical Report from Dr.
- o 05-06-10 Fax request for pre-authorization from Dr.
- o 05-17-10 Medical report from Dr.
- o 06-02-10 Request for IRO from the Claimant
- o 06-07-10 Confirmation of Receipt of Request for IRO from TDI
- o 06-07-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury to the right wrist on xx/xx/xx when a coworker's pickax handle struck him on the wrist, causing blunt trauma. The medical records indicate he had a healed right radial fracture with subsequent resorptive inflammatory arthropathy changes of the distal radius and ulna. There was dorsal displacement of the ulna and volar tilting of the lunate, suspicious for volar intercalated segmental instability.

The patient underwent a RME on March 8, 2010. The patient is a left-handed male who works in plant maintenance and repair. He is not currently working as he lost his job. He has a history of high blood pressure and diabetes. He has had a back surgery and four right wrist surgeries. His last surgery was in December 2009. He was last attending therapy in January. He is doing HEP. He is using Hydrocodone, Skelaxin, Relafen and Elavil with some benefit. He appears somewhat defensive and not very friendly. He has had at least three operations, the most recent was a Darrach procedure, which is an excision of the distal end of the ulna. He has not gotten benefit from the operations. He reports he is stronger since the injury. He reports appearing better after each operation, but then the deformity returns; the deformity being that of a swelling of the distal forearm. In this case it is due to the ulna, which is reportedly bowed from previous injury. Lifting and moving things increases his wrist pain. His average

pain is 5-6/10. He reports numbness in his fingers most of the time. He reports weakness in the right fingers, wrist and forearm. Most of his activities are limited by this weakness. He is 5' 11" and 252 pounds. No mottling or temperature changes were seen. He is unable to make a complete fist. He has no muscle atrophy. A deformity is seen of the right upper extremity on the distal one-third of the forearm, which appears to extend to the mid forearm as well. The records indicate this deformity is due a posteriorly displaced ulna and a bowed ulna. He has very limited supination of 5 degrees and pronation of 60 degrees. Supinator and pronator muscle strength is 2+/5 on the right. Right grip is 8 versus 64 on the left. Tinel's is negative. Phalen's could not be performed due decreased ROM. Sensation is decreased from the ulnar fingertips to the mid forearm. Two-point discrimination testing showed inconsistent results. He does not have a chronic pain syndrome. Norco could be weaned. He does not have CRPS and stellate ganglion blocks are not necessary. Another tendon sling procedure is not indicated. Psychologically he has unrealistic expectations from treatment. The best plan for this type of patient is to avoid further invasive procedures, including injections and any kind of surgery. He should participate in an interdisciplinary pain program that includes CBT and aggressive rehab with psychosocial counseling. Splinting could be reasonable but not on a continuous basis. HEP would be useful.

Medical report dated April 23, 2010 notes the patient has been seen for one year after an injury to the right wrist. He has undergone multiple operations, most recently being a Darrach procedure with a stabilization. He has more recently had an independent review. His grip strength is improving but he is still having a lot of issues with the ulnar stump and lack of stability. He has a prominent ulna that is tender to palpation. ROM shows 25 degrees of wrist extension and 17 degrees of flexion. Pronation is to about 90 degrees and supination to about 5 degrees. A custom fitted brace has not been authorized. He is asking about a fusion. The results of a fusion were explained. He is unsure about how to proceed. He will return in one month.

Medical report of May 17, 2010 indicates the patient's ulna displaces dorsally with attempts of weight bearing, as in moving from a sitting to a standing position using his arm to elevate himself. He has been treated conservatively with PT and strengthening exercises. Continued therapy as well as a splint have been denied. Further treatment by his pain therapist has also been denied. A fusion surgery was recently denied and conservative management was recommended, which is impossible as everything is being denied. Request is for appeal of return to therapy for fashioning of a custom splint. If this is denied then the fusion surgery is again requested. This surgery is not discussed in "Green's Operative Hand Surgery, however, it is an uncommon problem. People with pain and unstable joint do get fusions for relief.

Request for outpatient right wrist/forearm fusion with right iliac crest bone graft was considered in review on May 12, 2010 with recommendation for non-certification. The patient has a diagnosis of wrist contusion and limb pain. The patient is two years post injury and is 48 years old. He has had extensive treatment including four surgeries and multiple treatments for chronic pain including multiple stellate ganglion blocks and PT of 81 sessions. A recent RME was performed resulting in an opinion that further surgery was not likely to be successful. Only conservative treatment was recommended. His condition and possible additional treatment are beyond the scope of ODG. See Green's Textbook on Hand Surgery.

Request for reconsideration outpatient right wrist/forearm fusion with right iliac crest bone graft was considered in review on May 26, 2010 with recommendation for non-certification. The patient was status post multiple right wrist excision, status post triangular fibrocartilage complex (TFCC) excision non-united ulnar styloid, statu post tendon sling procedure and a Darrach procedure. He was also status post multiple brachial plexus blocks after each procedure which failed to improve his condition. He also had multiple stellate ganglion blocks with no benefit. He had multiple local wrist injections with temporary relief with persistent right wrist and distal forearm pain. He is status post remote fracture at the forearm at the middle and distal 2/3 with ulnar bowing and degenerative joint disease of the radius and ulna. With such a history he would not benefit from additional surgical procedures. Current ODGs fail to identify any benefits from proposed stabilization of the wrist.

Request was made for an IRO.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Per ODG: Wrist fusion is recommended in severe posttraumatic arthritis of the wrist or thumb or digit after 6 months of conservative therapy.

Per the literature: Wrist fusion surgery is indicated for patients who are active with involvement of only a single wrist and sparing the opposite wrist.

The patient has a deformity of the right upper extremity on the distal one-third of the forearm, which appears to extend to the mid forearm as well, which is due a posteriorly displaced ulna and a bowed ulna. He has had an ulnar shortening and has issues with the ulnar stump and lack of stability. He has a prominent ulna that is tender to palpation. He has had multiple surgical attempts with recurrence of the deformity following each surgery. A custom fitted brace was supported by the IME opinions and could be reasonable if not worn continuously. IME opinions opined that the patient has unrealistic expectations from treatment and that the best plan for this type of patient is to avoid further invasive procedures, including injections and any kind of surgery. He should participate in an interdisciplinary pain program that includes CBT and aggressive rehab with psychosocial counseling. HEP would be useful.

A custom fitted brace could be reasonable per IME opinions considering the continuing pain and weakness at the wrist. The patient has continuing pain and weakness at the right wrist and has failed surgical correction several times. ODG does support wrist fusion for young active patients. ODG notes that patients may have functional limitations interfering with lifestyle, and total fusion does not always result in complete pain relief. The patient does have significant arthritis of the wrist, which is not being

disputed. A wrist fusion is indicated for severe arthritis and deformity not resolved by other measures.

Therefore, my recommendation is to disagree with the previous non-certification of the request for outpatient right wrist/forearm fusion with right iliac crest bone graft.

The IRO's decision is consistent with the following guidelines:

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

____ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

____ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

____ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

____ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

____ INTERQUAL CRITERIA

____ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

____ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

____ MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

____ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

____ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

____ TEXAS TACADA GUIDELINES

____ TMF SCREENING CRITERIA MANUAL

____ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

The Official Disability Guidelines 06-03-2010 Forearm Wrist and Hand Chapter: Arthrodesis (fusion):

Recommended in severe posttraumatic arthritis of the wrist or thumb or digit after 6 months of conservative therapy. Total wrist arthrodesis is regarded as the most predictable way to relieve the pain of posttraumatic wrist arthritis. Total wrist fusion diminishes pain, but wrist function is sacrificed. Patients may have functional limitations interfering with lifestyle, and total fusion does not always result in complete pain relief. Arthrodesis (fusion) provides a pain-free stable joint with a sacrifice of motion. It may be indicated in young patients in whom heavy loading is likely; in joints with a fixed, painful deformity, instability, or loss of motor; and in the salvage of failed implant arthroplasty. Arthrodesis of the metacarpophalangeal joint of the thumb gives reliable results, with high patient acceptance, but does not result in an entirely normal thumb or hand function. Postoperative treatment: Plaster splint for 5 days, then early functional treatment.

Advances in Hand and Wrist Arthritis Surgery. Edited By: Magee E. Saewert, MS, PA-C, Thomas Trumble, M.D. Last updated Wednesday, December 30, 2009:

When the arthritis does not involve all the joint surfaces such as found in the SLAC arthritis, a partial wrist fusion can be extremely successful in relieving pain while still preserving some joint motion. In this fusion, several arthritic bones are fused together using a small ring-like plate that has been referred to as the 'Spider plate' because of the way the eight screws branch out like the likes of a spider. Surgery is performed with a special technique that uses specialized instruments to remove the

arthritic bone surfaces and fuse them together while preserving joint surfaces that are normal to preserve joint motion.

When arthritis is more extensive and the entire wrist joint is involved, the surgeons needs to perform either wrist replacement surgery where the joint surfaces are removed and are replaced with an artificial joint, or perform a wrist fusion surgery. Joint replacement surgery is indicated for patients with many areas of arthritis in their hands, arms and legs with a lower activity level and need to preserve as much motion as possible to do their activities of daily living. Wrist fusion surgery is indicated for patients who are active with involvement of only a single wrist and sparing the opposite wrist. Wrist fusion relieves pain and provides stability, but eliminates wrist motion. This technique is particularly helpful where an injury has caused the destruction of one wrist joint but the opposite wrist joint has no evidence of arthritis.

[http://www.orthop.washington.edu/uw/handandwrist/tabID__3374/ItemID__164/PageID__3/Articles/Default.aspx]