CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

May 23, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Darrach Resection Arthroplasty of the Distal Ulna

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Orthopedic Surgery with over 16 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Overturned (Disagree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX year old XXXX who sustained an injury on XXXX while XXXX was XXXX. XXXX onto right wrist/forearm. X-rays dated XXXX showed a Colles fracture. XXXX was initially treated with reduction, splint, sling, and XX. XXXX was seen for 24 physical therapy visit to date and continued to have right neck, right shoulder and right wrist pain.

On XXXX, the claimant presented to XXXX with continued discomfort. X-rays revealed some slight radial deviation compared to displacement from the previous radiographs and pretty good overall alignment. Plan: Short arm cast with some volar flexion and ulnar deviation.

On XXXX, the claimant presented to XXXX with continued discomfort. X-rays revealed slight radial displacement with some mild shortening. Plan: Convert XXXX to a gauntlet brace and encourage range of motion exercises. Refer for formal physical therapy.

On XXXX, the claimant presented to XXXX for recheck of wrist pain. XXXX reported that due to some underlying osteoporosis and some comminution XXXX fracture settled and maintained good alignment, but XXXX just settled, so XXXX ended-up being ulnar positive and left XXXX with some radial deviation. XXXX continued to experience pain and limitation in function. XXXX had physical therapy, but without any real improvement. On physical examination: Sensation was intact. XXXX had a very prominent ulnar styloid. XXXX had some radial deviation of the wrist. XXXX had some generalized swelling in XXXX wrist. XXXX had decreased range of motion of the wrist. XXXX had weakness with flexion of the ring and small finger. X-rays revealed for the most part maintained good alignment. XXXX had some significant settling, which left XXXX ulnar positive. Plan: Refer XXXX to a hand surgeon to discuss the possibility of an osteotomy.

On XXXX, the claimant presented to XXXX with right wrist pain. On examination there was obvious

radial deformity in the coronal plane. There was a prominent distal ulna and exquisite tenderness to palpation over the distal ulna. The patient poorly tolerated extension and ulnar deviation. Pronosupination was passive and the DRUJ was stable. Small joint range of motion was supple. The patient exhibited 45 degrees of wrist flexion and extension, 30 degrees of radial deviation, and ulnar deviation to neutral. There was no obvious deficit either vascular or neurologic. Assessment: Colles fracture of right radius and ulnocarpal impingement syndrome. Plan: Given that XXXX is a smoker, I believe osteotomy is contraindicated. Therefore, I recommend consideration of Darrach resection arthroplasty of the distal ulna.

On XXXX, XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There is incomplete conservative care based on the guidelines.

On XXXX, XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Although it was documented that the patient had tried physical therapy as part of XXXX conservative treatment, the patient was still at XXXX XX post-injury status. Given the age of injury, the exhaustion of conservative treatment after XX of conservative treatment was not still addressed.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for Darrach resection arthoplasty of the distal ulna is medically necessary.

This patient is a XXXX year-old XXXX who XXXX and sustained a distal radius (Colles') fracture in XXXX. The fracture was treated with a cast. XXXX currently has shortening of the distal radius, which has left XXXX ulnocarpal impingement syndrome. On examination, XXXX has limited wrist motion and pain. XXXX has completed XX of conservative care.

The consulting hand surgeon has recommended a Darrach procedure, as an alternative to an ulnar shortening procedure. XXXX is a heavy smoker, which may limit XXXX ability to heal an osteotomy, placing XXXX at risk for a non-union.

The Official Disability Guidelines (ODG) supports the Darrach procedure in patients with rheumatoid arthritis. This procedure is also commonly performed in elderly patients following a malunion of a Colles' fracture, with a prominent distal ulna.

Since this patient is a poor candidate for osteotomy, the Darrach procedure is XXXX only surgical option. XXXX condition will not improve without this procedure. The recommended surgery is appropriate for this patient.

PER ODG:

Arthroplasty, distal radioulnar joint (DRUJ)	Recommended as an option for wrist pain from rheumatoid arthritis after 12 months of conservative treatment. Among the devices available are the Aptis prosthesis, the Herbert prosthesis, and the Scheker device. See also Arthroplasty, finger and/or thumb (joint replacement); Arthroplasty, wrist (joint replacement); DRUJ posttraumatic arthritis surgery; Triangular fibrocartilage complex (TFCC) reconstruction. **Criteria for Arthroplasty, distal radioulnar joint (DRUJ):** - Diagnosis of rheumatoid arthritis

	- Pain and functional limitations continue after 12 months of conservative treatment There are no quality prospective studies, but a variety of lower quality case series, primarily covering use for rheumatoid arthritis, but there is insufficient evidence for use in other diagnoses. Wrist arthroplasty should be rare in workers' comp. The distal radioulnar joint (DRUJ) is commonly affected in rheumatoid arthritis and is associated with significant functional morbidity. The DRUJ replacement prosthesis is an alternative to salvage procedures, and it may enable full range of motion as well as the ability to grip and lift weights encountered in daily activities. Studies show good long-term survival and acceptable patient satisfaction, but substantial disability remains in all groups. Patients should be counseled about the expected outcomes of this specialized procedure as they pertain to the patient's specific situation. (Ahmed, 2011) (van Schoonhoven, 2012) (Sabo, 2014) (Galvis, 2014)

Arthroplasty, wrist (joint replacement)	Not recommended for the wrist. See also Carpectomy. For average hospital LOS if criteria are met, see Hospital length of stay (LOS). Every effort should be made to preserve the maximum pain-free movement of the joint, and arthroplasty (artificial joint replacement) provides improved stability and earlier motion, but complications are common and include implant fracture, lateral instability of the PIP joint, and, occasionally, synovitis. (Ellis, 1989) (Lourie, 2001) (Edmunds, 1994) Because of long-term deterioration, including an unacceptable revision rate (over 90% requiring a salvage procedure where the prosthesis was removed and an arthrodesis was performed), we currently do not consider the wrist prosthesis to be suitable in patients with rheumatoid arthritis. (Radmer, 2003) With the advent of newer prosthetic designs, total wrist arthroplasty may provide a functional range of motion, better wrist balance, reduced risk of loosening, and better implant stability. Candidates for total wrist arthroplasty might be patients who exhibit far-advanced disease at the wrist and who might be considered as candidates for arthrodesis, but in whom the permanent loss of motion would represent a significant handicap. With bilateral disease, a combination of a total wrist arthroplasty and a contralateral total wrist fusion may be an option. Numerous implants have been used; however, major complications of implant loosening and wear of the components are common. (Adams, 2004)

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**