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Notice of Independent Review Decision

DATE OF REVIEW: 03/29/2012

IRO CASE: #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right wrist Pisiform Excision CPT-25210

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

Board Certified Hand Surgeon

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Clinical records Dr. 07/30/10-02/17/11
Operative report 10/14/10
Clinical records Dr. 03/01/11-02/16/12
MR arthrogram right wrist 03/02/12

Radiographic report right wrist 03/08/12
Utilization review determination 02/22/12
Utilization review determination 02/28/12

PATIENT CLINICAL HISTORY:

The claimant is a female who has a date of injury of xx/xx/xx. She presented with bilateral hand pain secondary to repetitive stress/cumulative trauma. She was initially evaluated with complaints of right wrist pain. She was ultimately taken to surgery and underwent ulnar nerve transposition with fractional lengthening of the flexor pronator mass tenolysis/decompression. The claimant had post-operative physical therapy. Records indicate that the claimant had continued complaints of right wrist pain over the pisotriquetral joint. Records indicate that the claimant has received conservative treatment which included oral medications physical therapy splinting and injections into the pisiform area. The record includes an MR arthrogram dated 03/02/12 which notes marrow signal on either side of the pisiform triquetral joint appears maintained. Contrast is present in the radiocarpal and intracarpal joints as observed through the entire length of the lunotriquetral interval however only partially seen at the distal scapholunate interval. There is an irregularity of possible fenestration of the lower component of the lunotriquetral ligament. The intracarpal spacing in the scapholunate ligament and TFCC are maintained. There is an abnormal appearance of contrast in the intracarpal joint suggestive of a contrast leak at the proximal carpal row as the volar component of the lunotriquetral ligament appears ill defined a leak may have occurred at this point. The intercarpal joints including the pisiform triquetral show no apparent abnormality. Plain radiographs of the right wrist dated 03/08/12 show no acute bony abnormalities. The request is for a right wrist pisiform excision. The initial review was performed on 02/22/12 by Dr. who notes that he was unable to speak with Dr. he reports that pisiform excision results in a high success rate for treatment of pisiform fracture that can go on and develop chronic pain situations. Unfortunately in this case there is no clinical imaging or understanding of the pisiform injury dating back to the claimant's work related injury for diagnosis of repetitive stress he notes based on the above there would be no clinical indication for pisiform removal based on a lack of understanding of pathology of the joint. A subsequent appeal request was reviewed by Dr. on 02/28/12 who upholds the previous denial noting that a peer to peer was performed with Dr. additional clinical information was provided by facsimile. The additional information did not include any documentation of even plain x-rays of the claimant's wrist simple wrist x-rays and an MRI scan would appear appropriate to have documented the medical records before performing the pisiform excision. He opines that the prior denial was appropriate and should be upheld.

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

The request for pisiform right wrist pisiform excision CPT 25210 is not supported as medically necessary and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant has a history repetitive trauma to the bilateral upper extremities. The claimant has received appropriate conservative care over the years and has undergone a cubital tunnel or ulnar nerve transposition. The claimant subsequently has had

complaints of wrist pain that have been unremitting despite bracing occupational therapy and injections. The most recent imaging studies provided do not show any pathology involving the pisiform. There appears to be evidence of pathology involving the lunotriquetral ligament but no specific findings involving the pisiform. It is therefore opined that the previous utilization review determinations were appropriate and are subsequently upheld.

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

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

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

The 2012 Official Disability Guidelines, 17th edition, The Work Loss Data Institute. Online edition. Does not specifically address this request.

Wheeless's Textbook of Orthopedics

Pisiform:

- Discussion:
- located in anterolateral portion of triquetrium (may be a source of DJD and ulnar wrist pain);
- pisiform forms medial border of tunnel of Guyon (transporting ulnar nerve and artery);
- tendinous and ligamentous attachements;
- FCU tendon: pisiform bone is located w/ in FCU tendon;
- abductor digiti quinti muscle;
- pisometacarpal ligament;
- pisohamate ligament;
- extensor retinaculum;
- flexor retinaculum (transverse carpal ligament)

- Radiographs:
- 15 reversed oblique view:
- pisotriquetral joint is best seen with 30 deg of wrist supination or utilizing the carpal tunnel view;
- calcific deposits, which occassionally form at site of insertion of tendon, can cause severe pain;

- Treatment of Frx:
- pts that sustain frx of pisiform most often go on to heal w/o posttraumatic osteoarthritis;
- frequently these pts have ulnar neuropathies, esp w/ wrist frxs or subluxation or dislocation of the pisiform;
- cause of pain about pisiform is chronic calcific tendinitis of FCU;
- excision of pisiform w/ pain localized to pisotriquetral joint provides almost complete pain relief, w/ minimal
reduction of grip strength or motion;

Pierre, A., et al TREATMENT OF PISOTRIQUETRAL PAIN BY EXCISION OF THE PISIFORM BONE: FIFTEEN CASES. Copyright © 2012 BRITISH EDITORIAL SOCIETY OF BONE AND JOINT SURGERY

Purpose: The pisitriquetral articulation can be a source of pain, particularly after trauma. If conservative treatment fails, pisiformectomy appears to be the best alternative. The purpose of this work was to assess clinical and functional outcome after pisiformectomy.

Material and method: Thirteen patients were reviewed 31.5 months (mean) after pisiformectomy. Two patients had a bilateral procedure giving 15 pisiformectomies. Occupation-related trauma was the principal cause. Four patients also had ulnar neuropathy. The same operative technique was used for all patients and a visual analogue scale was used to assess pain.
Results: There were no postoperative complications. At last follow-up, outcome was excellent in twelve cases, good in two and fair in one (n=15). Residual pain was scored a mean 0.8 points versus 6.4 points preoperatively ($p<0.001$). Wrist motion was improved after surgery.

Conclusion: There are many causes of pisotriquetral disease, but trauma, or microtraum, predominates. Pisiformectomy is the best treatment after failure or deterioration of results of conservative treatment. It must be remembered however that pisotriquetral disease may be a revealing sign of a regional disorder that must be identified.