

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0019125 |                              |            |
| <b>Date Assigned:</b> | 06/11/2014   | <b>Date of Injury:</b>       | 08/02/2013 |
| <b>Decision Date:</b> | 08/08/2014   | <b>UR Denial Date:</b>       | 01/22/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/14/2014 |

### 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 Physical Medicine and Rehabilitation, Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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:

This patient is a 48-year-old female with a date of injury 08/02/2013. Per treating physician's report 10/01/2013, patient presents with left thumb pain, wrist pain, weakness in left hand, numbness and tingling, with a list of diagnoses: 1. Status post major fall, landing on bilateral upper extremities, bilateral lower extremities. 2. Knees, left basal joint major ligamentous injury, MRI verified major subluxation. 3. Left wrist diffuse nonspecific pain. 4. Left de Quervain's disease. 5. Left median neuropathy, carpal tunnel. 6. Left wrist MRI, potential pisohamate ligament, rigid straight partial tear of TFCC. 7. History of SLE, nonindustrial. Recommendation was for left first dorsal compartment release, major reconstruction numerous ligaments and capsule left trapeziometacarpal joint, specialized thumb spica, immobilization of left thumb. Immediate postoperative therapy recommendations include OT 3 x 4, special thumb spica splint, movement of the left thumb, aggressive immediate full range of motion of the left 4 fingers, and no movement of the left wrist, continuous passive range of motion for finger (it was recommended for 30 days), Thermocool compression therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OCCUPATIONAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS WITH THE CHT: ONE DAY AFTER SURGERY:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Forearm, Wrist, & Hand (MTUS post-surgical pg18-20) Page(s): 18-20.

**Decision rationale:** This patient is recommended for surgical intervention of thumb including de Quervain's release, TFCC repair. MTUS guidelines for postoperative therapy treatments recommend anywhere from 14 to 18 sessions for tendon repairs, synovitis and tenosynovitis surgical treatments, and 10 sessions for TFCC debridement. Given the recommended surgery, the request of 12 sessions of occupational therapy appears reasonable and consistent with MTUS guidelines. Therefore the request is medically necessary.

**POSTOPERATIVE MEDICATION NORCO 10-325MG #90 WITH ONE (1) REFILL:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain (MTUS 60,61) Page(s): 60, 61.

**Decision rationale:** This patient presents with persistent wrist/hand pain. The request is for Norco #90 to be used for postoperative pain. MTUS guidelines support use of medications for postoperative pain as well as chronic moderately severe pain, particularly for short term. The current request is for postoperative pain for #90 with 1 refill, which appears reasonable and consistent with MTUS guidelines. Therefore is medically necessary.

**CONTINUOUS PASSIVE MOTION (CPM) ON THE FINGER (30 DAYS):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines, forearm, wrist and hand chapter online for: Continuous passive motion (CPM).

**Decision rationale:** This patient presents with persistent thumb, wrist/hand pain. The proposed surgery is major reconstruction numerous ligaments and capsule left trapeziometacarpal joint along with left first dorsal compartment release. The treating physician has asked for postoperative CPM for 30 days use. ODG guidelines for CPM following surgery, particularly for flexor tendon repair, recommend it. There is no duration of date recommended. It states that it can be quite helpful for postoperative rehabilitation. Although the current request is not specific to flexor tendon repair, the request is for major reconstruction of numerous ligaments and use of CPM unit may be appropriate for 30 days. Therefore the request is medically necessary.

**THERMO COOL COMPRESSION THERAPY FOR THIRTY (30) DAYS:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG forearm, wrist and hand chapter, online for: Contrast bath therapy.

**Decision rationale:** This patient is recommended for a rather complex surgery of the thumb and wrist ligaments. The request is for ThermoCool compression therapy for 30 days following surgery. Regarding contrast bath therapy, ODG guidelines recommend it as an option for extremities affected by reflex sympathetic dystrophy, acute edema resulting from trauma, synovitis/tenosynovitis if used as an adjunct to a program of evidence-based conservative care. There is no discussion in MTUS or ODG guidelines specific to ThermoCool compression therapy following surgery. Given that contrast bath therapy can be quite helpful for hand conditions, the request for ThermoCool compression therapy for 30 days following surgery appears reasonable. Therefore the request is medically necessary.

**POSTOPERATIVE MEDICATION: KEFLEX 500MG #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: J Hand Surg Am. 2010 Feb;35(2):189-96. doi: 10.1016/j.jhsa.2009.11.012. Rate of infection after carpal tunnel release surgery and effect of antibiotic prophylaxis.

**Decision rationale:** This patient is proposed for wrist/hand surgery. The treating physician asked for postoperative use of Keflex 500 mg #30. MTUS and ODG guidelines do not discuss postoperative antibiotic use. However, review of the literature shows that postoperative use of antibiotics did not decrease the risk of infection in patients undergoing carpal tunnel release. This patient is proposed to undergo hand/wrist surgery, similar complexity and exposure time as carpal tunnel syndrome. This particular study is from General Hand Surgery, America 2010, under the heading Rate of Infection after Carpal Tunnel Release Surgery and Effective Antibiotic Prophylaxis. Given the lack of medical evidence that postoperative prophylactic use of antibiotics can be beneficial, the request is not medically necessary.

**PREOPERATIVE MEDICATION: NORCO 10-325 #90 WITH ONE (1) REFILL:**  
Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain (MTUS 60,61) Page(s): 60-61.

**Decision rationale:** This patient presents with chronic persistent wrist/hand, thumb pain. The treating physician has asked for preoperative use of Norco #90. Review of the reports does not show that this patient has been on opiates. MTUS guidelines do support trial of opiates at least for short term to manage persistent musculoskeletal pains. Therefore the request is medically necessary for trial of opiates on this patient.