

<b>Case Number:</b>	CM15-0136842		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	03/27/2014
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	07/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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(n) 59 year old female, who sustained an industrial injury on 3/27/14. She reported pain in her left wrist and hand related to lifting a heavy object. The injured worker was diagnosed as having left wrist dorsal compartment tendonitis status post surgery, complex regional pain syndrome and radial nerve entrapment. Treatment to date has included a TENs unit, left wrist DeQuevain's surgery in 11/2014 and a left wrist MRI on 5/5/15. On 3/5/15, the treating physician noted the results of the NCS study indicating mild left demyelinating cubital tunnel syndrome. As of the PR2 dated 6/15/15, the injured worker reports continued pain in her left wrist and left hand. Objective findings include moderate tenderness to the radial side of the wrist directly over the dorsal compartment, full range of motion and a positive Finkelstein's test. The treating physician requested a revision of left first dorsal compartment tendon release.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Revision of left first dorsal compartment tendon release:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271 272.

**Decision rationale:** The patient is a 59 year old female with possible signs and symptoms of left DeQuervain's tenosynovitis, that could be recurrent or as a result of an inadequate release in November 2014. She has complicating factors of possible previous injury to the superficial branch of the radial nerve, suggestion of a possible CRPS, mild left cubital syndrome on previous electrodiagnostic studies and evidence of a clinical cervical radiculopathy. A recent MRI report of the left wrist only demonstrated mild osteo arthritic changes of the 1st CMC joint and would not likely explain her condition. Conservative management has included medical management, acupuncture and activity modification. A recent course of splinting has not been documented and a steroid injection was declined by the patient due to an unspecified previous negative reaction. From ACOEM, Chapter 11, page 271 DeQuervain's Syndrome: The majority of patients with DeQuervain's syndrome will have resolution of symptoms with conservative treatment. Under unusual circumstances of persistent pain at the wrist and limitation of function, surgery may be an option for treating DeQuervain's tendinitis. Surgery, however, carries similar risks and complications as those already mentioned above (see A, Carpal Tunnel Syndrome), including the possibility of damage to the radial nerve at the wrist because it is in the area of the incision. Further from Table 11-7, Initial injection into tendon sheath for clearly diagnosed cases of DeQuervain's syndrome, tenosynovitis, or trigger finger (D). Splinting is considered a first- line treatment as well. Overall, given the complexity of the clinical presentation and previous attempt at DeQuervain's release, a dedicated conservative trial should be documented, including splinting. The previous negative response from the steroid injection of the feet should be detailed to see if this was an allergic reaction. As suggested by the UR, an alternative to a steroid injection may to check the response to a local anesthetic in the area of the 1st dorsal compartment to help facilitate the diagnosis. Without this, the procedure should not be considered medically necessary.