

Case Number:	CM15-0149543		
Date Assigned:	08/12/2015	Date of Injury:	04/21/2015
Decision Date:	09/09/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	07/31/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 51-year-old male, who sustained an industrial injury on 4-21-15. He has reported initial complaints of a crush injury to the right and left index fingers working as a machine operator. The diagnoses have included status post traumatic amputation of the right index finger, status post left index finger crush laceration, and medication induced gastritis and rule out Complex regional pain syndrome (CRPS). Treatment to date has included medications, surgery, wound care, physical therapy and other modalities. Currently, as per the physician progress note dated 7-7-15, the injured worker complains of pain in both hands especially the right and left index fingers. The injured worker is status post traumatic amputation of the right index finger and status post left index finger crush laceration. He continues to complain of excruciating pain along the stump site along with phantom sensation. He rates the pain 9 out of 10 on the pain scale. He complains of stiffness in the interphalangeal joint and proximal joint. He also has hypersensitivity and tenderness in each index finger. The injured worker is going to wound care clinic. The objective findings reveal that he guards his hands against being touched. The right index finger is wrapped in gauze and removal of the dressing reveals that the incisions are open to air with no active drainage. The range of motion is limited secondary to pain. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the right hand dated 6-15-15 reveals amputation of the second phalanx at the level of the middle phalanx and subchondral cyst in the head of the second metacarpal bone. Magnetic Resonance Imaging (MRI) of the left hand dated 6-15-15 that reveals dorsal angulation of the fourth middle phalanx,

volar angulation of the fifth distal phalanx, subchondral cyst in the head of the second metacarpal bone and subcutaneous edema in the second phalanx. The current medications included Norco, Anaprox, Prilosec and Neurontin. Work status is temporary totally disabled for the next six weeks. The physician requested treatment included 3 Visits for Wound Care to bilateral Index fingers at 1 time a week for 3 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 Visits for Wound Care to bilateral Index fingers at 1 time a week for 3 weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Wound dressings.

Decision rationale: MTUS is silent regarding wound care. ODG states "Recommended as indicated below. Recommend the following combinations: for chronic wounds, (1) debridement stage, hydrogels; (2) granulation stage, foam and low-adherence dressings; and (3) epithelialization stage, hydrocolloid and low-adherence dressings; and for the epithelialization stage of acute wounds, low-adherence dressings. For specific situations, the following dressings are favored: for fragile skin, low-adherence dressings; for hemorrhagic wounds, alginates; and for malodorous wounds, activated charcoal. [The various stages of wound healing are debridement or the stage in which debridement is required; granulation, in which the wound is recovered by newly formed, pink granular tissue (granulation tissue); and epithelialization, in which keratinocytes migrate across the wound surface.] A moist environment facilitates wound healing more so than allowing the wound to air-dry. There are only weak levels of evidence on the clinical efficacy of modern dressings compared with saline or paraffin gauze in terms of healing, with the exception of hydrocolloids. There was no evidence that any of the modern dressings was better than another, or better than saline or paraffin gauze, in terms of general performance criteria. Hydrocolloid dressings proved superior to saline gauze or paraffin gauze dressings for the complete healing of chronic wounds, and alginates were better than other modern dressings for debriding necrotic wounds. Hydrofiber and foam dressings, when compared with other traditional dressings or a silver-coated dressing, respectively, reduced time to healing of acute wounds. There is no evidence to support claims that specific dressings, such as silver-containing antibacterial dressings, are most appropriate for selected indications, such as care of infected wounds or prevention of infection. (Chaby, 2007) There is no evidence that using tap water to cleanse acute wounds in adult's increases infection and some evidence that it reduces it. Drinkable tap water applied topically is as effective as normal saline for cleansing a wound, according to this Cochrane review. Various solutions have been recommended for cleansing wounds, however normal saline has been favored as it is an isotonic solution and does not interfere with the normal healing process. Antiseptic preparations have been traditionally used, but animal models suggest that antiseptics may actually hinder healing. (Fernandez, 2008) Although wounds may be irrigated with saline or tap water, povidone iodine, detergents, and

hydrogen peroxide should be avoided (level of evidence, B). For skin laceration repair, suturing is the preferred technique (level of evidence, C). Compared with sutures, tissue adhesives are comparable in cosmetic results, rates of dehiscence, and the risk for infection (level of evidence, A). To promote wound healing, applying white petrolatum to a sterile wound is as effective as applying an antibiotic ointment (level of evidence, B). Areas of high skin tension, such as over joints, or areas with a thick dermis, such as the back, should be closed with sutures or staples. Areas with low skin tension, such as the face, shin, and dorsal hand, may be repaired with tissue adhesives. Absorbable sutures usually dissolve within 4 to 8 weeks. Rates of wound dehiscence and infection appear similar between absorbable and nonabsorbable sutures, and cosmetic results are similar between these 2 types of suture. A horizontal mattress suture is usually best for high-tension wounds or wounds with fragile skin, and the vertical mattress technique is best for averting wound edges in anatomic locations, which tend to invert, such as the posterior aspect of the neck. Subcuticular running suture is ideal for low-tension, cosmetically important wounds. Tissue adhesive is convenient and may be cost effective because no follow-up for suture removal is necessary. Patients at a higher risk of poor healing, including patients with diabetes, should not receive tissue adhesive. For scalp lacerations, less than 10 cm long, strands of hair at least 3 cm in length from opposing sides of the wound may be twisted and fixed with a drop of tissue adhesive to close the laceration. Although many patients are told to keep the sutured laceration dry for 24 hours, research has demonstrated that wetting the area after only 12 hours does not increase the risk for infection. Sutures may usually be removed at the following times for different anatomic locations: Face: 3 to 5 days; Scalp: 7 to 10 days; Arms: 7 to 10 days; Trunk: 10 to 14 days; Legs: 10 to 14 days; Hands or feet: 10 to 14 days; Palms or soles: 14 to 21 days. (Forsch, 2008) See also Hyperbaric oxygen therapy; Vasopneumatic devices; Versajet hydrosurgery system; & Skin grafts."The medical documentation provided indicate this patient had a traumatic amputation and crush injury to the bilateral hands. With the described mechanism of injury and bilateral hand involvement, it is reasonable for this patient to continue wound care as requested. The medical documentation provided indicate this patient has an open wounds that should continue to be monitored. As such, the request for 3 Visits for Wound Care to bilateral Index fingers at 1 time a week for 3 weeks is medically necessary.