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| Case Number: | CM15-0207294 | | |
| Date Assigned: | 10/26/2015 | Date of Injury: | 11/01/2008 |
| Decision Date: | 12/07/2015 | UR Denial Date: | 09/25/2015 |
| Priority: | Standard | Application Received: | 10/21/2015 |

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 63 year old female injured worker suffered an industrial injury on 11-1-2008. The diagnoses included wrist tendinitis-bursitis, DeQuervain's and trigger finger. On 7-16-2015 the provider reported the magnetic resonance imaging of the right wrist revealed degenerative changes of the TFCC. There was also subchondral edema within proximal lunate. The provider noted it was suggestive of ulnar impaction syndrome. There was also subchondral stenosis if the radiocarpal joint. The provider noted the diagnosis of bilateral carpal tunnel syndrome. The injured worker noted severe constant numbness, tingling and burning pain of the right and left wrist. On exam the grip strength was decreased and exquisite tenderness to the right wrist. On 8-27-2015 the provider reported chronic pain in the right wrist with numbness and tingling to the 4th and 5th fingers, triggering if the first finger and pain in the first dorsal compartment. Prior treatments included right carpal tunnel release. The electromyography studies 8-17-2015 revealed no pathological findings. Request for Authorization date was 9-18-2015. On 9-22-2015 the provider noted a discussion regarding denial of surgery. The provider noted that the reviewing physical acknowledge failed conservative treatment including surgery, physical therapy and medication. The provider noted that the reviewer indicated the injured worker did fail to improve with "the prolifera of conservative treatment". The Utilization Review on 9-25-2015 determined non-certification for De Quervain's release surgery, right wrist, arthroscopy for TFCC repair and right hand release of 1st thumb digit trigger finger.

IMR ISSUES, DECISIONS AND RATIONALES

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

De Quervain's release surgery, right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations, Summary.

Decision rationale: The patient is a 63 year old female with signs and symptoms of a possible DeQuervain's tenosynovitis. She has wrist pain overlying the 1st dorsal compartment with a positive Finkelstein's sign. Her conservative management has included activity modification, medical management and physical therapy. However, failure of splinting and steroid injection has not been documented. The requesting surgeon only states that the patient would like to refrain from any steroid injections. There is no clear documentation of a previous adverse reaction, allergic reaction or other reason to justify refusal. Splinting and a steroid injection are specifically recommended in ACOEM. Thus, without failure of recommended reasonable conservative management, right DeQuervain's release should not be considered medically necessary. From page 271, Chapter 11, ACOEM, "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. From page 272, Table 11-7, the following is recommended: "Initial injection into tendon sheath for clearly diagnosed cases of DeQuervain's syndrome, tenosynovitis, or trigger finger."

Arthroscopy for TFCC repair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Forearm, Wrist & Hand - Triangular fibrocartilage complex (TFCC) reconstruction.

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 and hand, diagnostic arthroscopy, TFCC reconstruction.

Decision rationale: The patient is a 63 year old female with chronic right wrist pain and a MRI which should abnormal findings of the TFCC. Her conservative management has included activity modification, medical management and physical therapy. However, failure of a splinting trial has not been documented. Thus, without failure of recommended reasonable conservative management, right wrist diagnostic arthroscopy with possible TFCC debridement should not be considered medically necessary. Once this has been sufficiently documented, then this could be reconsidered. From ODG, with respect to diagnostic arthroscopy: Recommended as an option if negative results on imaging, but symptoms continue after 4-12 weeks of conservative treatment. This study assessed the role of diagnostic arthroscopy following a wrist

injury in patients with normal standard radiographs, an unclear clinical diagnosis and persistent severe pain at 4 to 12 weeks. Patients with marked persistent post-traumatic symptoms despite conservative management are likely to have sustained ligament injuries despite normal radiographs. It is recommended that under these circumstances an arthroscopy may be carried out as soon as 4 weeks if the patient and surgeon wish to acutely repair significant ligament injuries. (Adolfsson, 2004) Per ODG: Triangular fibrocartilage complex (TFCC) reconstruction is recommended as an option. Arthroscopic repair of peripheral tears of the triangular fibrocartilage complex (TFCC) is a satisfactory method of repairing these injuries. Injuries to the triangular fibrocartilage complex are a cause of ulnar-sided wrist pain. The TFC is a complex structure that involves the central fibrocartilage articular disc, merging with the volar edge of the ulnocarpal ligaments and, at its dorsal edge, with the floors of the extensor carpi ulnaris and extensor digiti minimi. (Corso, 1997) (Shih, 2000) Triangular fibrocartilage complex (TFCC) tear reconstruction with partial extensor carpi ulnaris tendon combined with or without ulnar shortening procedure is an effective method for post-traumatic chronic TFCC tears with distal radioulnar joint (DRUJ) instability suggested by this study.

Right hand release of 1st thumb digit trigger finger: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations, Special Studies.

Decision rationale: The patient is a 63 year old female with signs and symptoms of a right thumb trigger finger. Her conservative management has included activity modification, medical management and physical therapy. However, failure of a steroid injection has not been documented. The requesting surgeon only states that the patient would like to refrain from any steroid injections. There is no clear documentation of a previous adverse reaction, allergic reaction or other reason to justify refusal. A steroid injection is specifically recommended in ACOEM. Thus, without failure of the recommended conservative management, right trigger thumb release should not be considered medically necessary. From ACOEM, Chapter 11, page 271, One or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. A procedure under local anesthesia may be necessary to permanently correct persistent triggering.