

<b>Case Number:</b>	CM15-0219687		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	07/09/2012
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic 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:

This injured worker is a 57-year-old female who sustained an industrial injury on 7/9/12. Injury was reported relative to cumulative trauma in her position as a workforce manager. She underwent surgical decompression of the right first dorsal compartment on 8/23/13. She reported complete relief of symptoms, followed by recurrence of pain. Conservative treatment had included splinting, anti-inflammatory medications, activity modification, and corticosteroid injections. The 7/28/15 right wrist MRI impression documented a 2.8 cm length of tendinosis and peritendinitis affecting the extensor carpi ulnaris tendon epicentered within the distal ulnar groove. There was tendinosis and peritendinitis of the extensor digitorum tendons of the 2nd and 3rd compartments without evidence for tendon tear. The 10/15/15 orthopedic report cited increased pain in the radial aspect of her wrist which was constant and radiated to the elbow. There was intermittent shooting pain at the thenar eminence on the right. She was not able to use the carpometacarpal (CMC) controller splint due to sensitivity at the radial styloid. Anti-inflammatory medications have provided no relief, topical cream was denied. She had two corticosteroid injections without relief. The right wrist exam documented a healed incision at the radial styloid of the first dorsal compartment. Finkelsteins test was negative. There was tenderness to palpation at the radial styloid, and mild to moderate tenderness at the right thumb CMC joint with negative grind test. There was no metacarpophalangeal (MCP) joint tenderness and no evidence of hyperextension at the MCP joint. There was obvious fat atrophy. There was a positive shoulder sign at the right thumb CMC joint. The second dorsal compartment was tender to palpation. X-rays of the right thumb showed well-preserved joint space at the radiocarpal, intercarpal, and CMC joints. The trapeziometacarpal joint space was well-

preserved. There was a small osteophyte radially. There was some small calcifications at the trapeziometacarpal joint laterally. Imaging was reviewed. The diagnosis included possible recurrence status post first dorsal compartment release, early right thumb CMC joint degenerative joint disease, and right second dorsal compartment tenosynovitis. The orthopedic surgeon noted that there was no imaging evidence of tendinitis in the first dorsal compartment but there as tendonitis at the second dorsal compartment. She had point tenderness at the 1st and 2nd dorsal compartments. She had pain at the right thumb CMC joint but this was intermittent and not the primary complaint. He opined based on the injured worker's complaints that the first and second dorsal compartment tendon sheath were the primary source of pain. Authorization was requested for right wrist revision incision of the first dorsal compartment tendon sheath and 2nd dorsal compartment, and 12 visits of post-operative occupational therapy. The 10/26/15 utilization review non-certified the request for right wrist surgery and associated post-op occupational therapy as there was no evidence of recurrent deQuervain's tenosynovitis or intersection syndrome to warrant the requested surgery.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 right wrist revision incision of the first dorsal compartment tendon sheath and incision of the second dorsal compartment: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.eorthopod.com/intersection-syndrome/topic/8> (date accessed: 10/24/2015).

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: de Quervain's tenosynovitis surgery.

**Decision rationale:** The California MTUS guidelines state that surgical consideration may be indicated for patients who fail to respond to conservative management, and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. MTUS guidelines state that 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. The Official Disability Guidelines recommend deQuervain's tenosynovitis surgery as an option if there are consistent signs and symptoms and the patient fails 3 months of conservative care with splinting and injection. Surgical treatment of deQuervain's tenosynovitis or hand/wrist tendinitis/tenosynovitis without a trial of conservative treatment, including work evaluation, is generally not indicated. Guideline criteria have been met. This injured worker presents with recurrence of right first dorsal compartment pain and new onset of 2nd dorsal compartment pain. Functional limitation was documented relative to work activities. Clinical exam findings and imaging evidence consistent with recurrent deQuervain's and dorsal compartment tendinosis. Detailed evidence of up to 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore the request is medically necessary.

## **12 Post-operative occupational therapy sessions: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, and Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

**Decision rationale:** The California Post-Surgical Treatment Guidelines for surgical treatment of radial styloid tenosynovitis suggest a general course of 14 post-operative physical medicine visits over 12 weeks, during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 7 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request is medically necessary.