

<b>Case Number:</b>	CM15-0083685		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	06/15/2013
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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 37 year old female who sustained an industrial injury on 06/15/13. Initial complaints include right wrist pain. Initial diagnoses include right wrist triangular fibrocartilage complex (TFCC) tear. Treatments to date include medications, right carpal tunnel release, physical therapy, cortisone injections. Diagnostic studies include a MR Arthrogram of the right wrist on 05/20/14 which showed a right wrist TFCC tear. Current complaints include right hand/wrist pain. Current diagnoses include a TFCC tear right wrist, carpal tunnel syndrome and de Quervain's tenosynovitis right wrist, intersectional syndrome right wrist. In a progress note dated 03/18/15 the treating provider reports the plan of care as a right wrist arthroscopy with first dorsal compartment release, TFCC repair vs debridement. The requested treatments includes a right wrist arthroscopy with first dorsal compartment release, TFCC repair vs debridement with 2 surgeons, postoperative physical therapy, micro cool, and multi Stim unit. MR arthrogram of the right wrist dated 4/9/15 noted tendinosis of the ECU tendon and extensor pollicis tendon. TFCC complex was noted to be intact. On 4/9/15 the patient was seen for chronic right wrist pain. A steroid was injected to the 1st dorsal compartment. The patient was placed on modified activity. On 5/6/15 the patient was noted to have had a positive response from the steroid injection but continued to have right wrist pain. Previously, the patient was noted to have pain along the TFCC of the right wrist. Previous conservative management had included NSAIDs, bracing, steroid injections, modified activity, and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right wrist arthroscopy & 1st dorsal compartment release. TCFF repair vs debridement to include 2 surgeons:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation ODG, Forearm, Wrist and Hand, Diagnostic Arthroscopy.

**Decision rationale:** The patient is a 37 year old female with chronic right wrist pain, to include symptoms related to the TFCC and 1st dorsal compartment (DeQuervain's). Conservative management has included NSAIDs, multiple steroid injections of the wrist and most recently the 1st dorsal compartment, bracing, physical therapy and activity modification. Previous MR arthrogram had demonstrated a possible TFCC tear; however, the most recent MR arthrogram noted only tendinosis of the ECU and extensor pollicis tendons. Previous UR had denied authorization for right wrist arthroscopy and DeQuervain's release, stating that conservative management had not been adequately documented including steroid injections. However, since that review the patient had undergone a steroid injection of the 1st dorsal compartment with some improvement, but with continued right wrist pain. From ACOEM, Chapter 11, page 272, 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. The patient is noted to have persistent pain despite exhaustive conservative management including a specific steroid injection. Therefore, 1st dorsal compartment release should be considered medically necessary. With respect to other sources of right wrist pain, the patient is noted to have pain other than at the 1st dorsal compartment. The TFCC area has been noted to be tender. She has undergone extensive conservative management without resolution. As the exact source of this additional pain is unknown, an arthroscopic evaluation should be considered medically necessary to evaluate the wrist more fully and provide possible treatment of her pain. From ODG, according to the Official Disability Guidelines, a diagnostic arthroscopy is recommended as an option after four to twelve (4-12) weeks of conservative care, with continued complaints of pain despite normal radiographs. The patient is noted to have undergone greater than 12 weeks of conservative care with continued significant wrist pain. MRI results do not provide a definitive diagnosis for her chronic pain. Previously, an MR arthrogram had noted a possible TFCC tear; however, this was not seen on a more recent study. Therefore, arthroscopy should be considered medically necessary.

**Associated surgical service: Post-op physical therapy 2x4:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 21, 22.

**Decision rationale:** As right wrist arthroscopy and 1st dorsal compartment release was considered medically necessary, post-op physical therapy should be considered medically necessary based on the following: Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04): Postsurgical treatment: 14 visits over 12 weeks Postsurgical physical medicine treatment period: 6 months; TFCC injuries-debridement (arthroscopic) [DWC]: Postsurgical treatment: 10 visits over 10 weeks Postsurgical physical medicine treatment period: 4 months. Therefore, as 2 procedures were considered medically necessary, the requested 8 visits would be consistent with the guidelines and considered medically necessary.

**Associated surgical service: Micro cool Unit times 6 weeks:** 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 ODG, continuous cold therapy.

**Decision rationale:** As the procedures were considered medically necessary, durable medical equipment can be considered. ACOEM guidelines do not address a micro cool unit. However, ODG addresses continuous cold therapy: The Official Disability Guidelines (ODG) indicate that Continuous Cold Therapy (CCT) is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than seven (7) days, including home use. Passive modalities, such as heat, should be minimized in favor of active treatments. Therefore a 6 week Micro cool unit should be considered medically necessary.

**Associated surgical service: Multi Stim Unit plus supplies times 3 month:** Upheld

**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 TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116, 117.

**Decision rationale:** As the procedures were considered medically necessary, DME may be considered. A 3 month Multi Stim Unit was requested. From page 116-117, state the following: TENS, post operative pain (transcutaneous electrical nerve stimulation) Recommended as a treatment option for acute post-operative pain in the first 30 days post- surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. (Solak, 2007) (Erdogan, 2005) It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. (Breit, 2004) (Rosenquist 2003) The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period. Therefore, a 3 month period would exceed the recommendations and should not be considered medically necessary.