

Case Number:	CM14-0131325		
Date Assigned:	09/19/2014	Date of Injury:	01/27/2012
Decision Date:	10/20/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/18/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 28-year-old male sustained an industrial injury on 1/27/12 due to a crush injury. He was milking a cow that pushed against him smashing his left thumb between 2 metal gate bars. He sustained a transverse fracture to the mid shaft of the proximal phalanx. A closed reduction with percutaneous pinning was performed on 2/1/12, but the reduction was lost. He underwent open reduction and internal fixation with plate and screws on 3/30/12. A revision open reduction and internal fixation with bone graft was subsequently performed on 7/11/12 secondary to non-union. The 6/13/14 initial treating physician report cited x-ray findings of non-union of the transverse proximal phalanx fracture with interphalangeal (IP) joint space interval 1-2 mm without evidence of arthrodesis. An Exogen bone growth stimulator was recommended. The 7/2/14 treating physician report indicated that patient had been using a bone growth stimulator for one week and was doing well. He only ached when he accidentally bumped his thumb or when he gripped objects. He was unable to flexion the interphalangeal (IP) joint of the thumb. There was 0 degrees of IP flexion or extension and very mild tenderness to palpation of the proximal phalanx. The treatment plan recommended left thumb tenolysis surgery due to scarring/adhesions of the extensor tendon to dorsal hardware impeding flexion of the IP joint. Surgery was to be performed by the treating physician plus one assistant. The 7/17/14 utilization review modified a request for left thumb tenolysis with 2 surgeons to left thumb tenolysis with 1 surgeon based on a peer-to-peer discussion with the surgeon who stated the surgery would be performed with one surgeon. The peer-to-peer discussion documented the surgeon's request to withdraw the requests for V-Pulse unit, chest x-ray and urinalysis. The requests for purchase of the V-Pulse unit, chest x-ray, EKG, and urinalysis were denied. The request for Micro Z Glove plus 3 months of supplies was modified to Micro Z Glove plus 1 month of supplies to allow a 30-day trial to

establish efficacy. The remainder of the associated surgical requests, including 8 visits of occupational therapy, was approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left thumb tenolysis: Overturned

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 Official Disability Guidelines (ODG) Forearm, Wrist & Hand, Tenolysis

Decision rationale: The California MTUS guidelines do not provide recommendations for tenolysis. The Official Disability Guidelines recommend tenolysis to remove adhesions that inhibit active flexion of digits. Tenolysis is useful to improve the function of tendons bound in scar tissue when the indications and techniques are carefully followed. Guideline criteria have been met. This patient is status post multiple left thumb surgeries following a transverse proximal phalanx fracture with non-union. He has 0 degrees of interphalangeal flexion and extension associated with adhesions that has failed to respond to extensive physical therapy. The 7/17/14 utilization review previously certified this procedure following a discussion with the surgeon noting all indications were met. Therefore, this request is medically necessary.

Include two surgeons: Overturned

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 Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule

Decision rationale: The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT Code 26440, there is a "1" in the assistant surgeon column. The request under consideration is for a flexor tenolysis performed by one surgeon with an assistant surgeon. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Purchase of V-Pulse unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines regarding Cothra VPULSE Compression and Cold Therapy System for P.

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, Cold Packs, Venous Thrombosis

Decision rationale: The California MTUS guidelines do not provide recommendations for cold compression therapy. The Official Disability Guidelines recommend cold therapy limited to cold packs for hand or finger procedures. Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. The administration of DVT prophylaxis is not generally recommended in upper extremity procedures. Guideline criteria have not been met. The patient had limited risk factors for venous thrombosis relative to the left thumb tenolysis procedure. There is no documentation that anticoagulation therapy would be contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis. Additionally, records documented the treating physician's request for withdrawal of this request. Therefore, this request is not medically necessary.

8 Occupational Therapy: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for extensor tenolysis suggest a general course of 18 post-operative visits over 4 months 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. 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 physical medicine period. This request for 8 post-operative occupational therapy visits is consistent with guideline recommendations for initial treatment. Therefore, this request is medically necessary.

Norco 10/325mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chronic Pain Treatment Guidelines regarding Norco; On going Management; . Decision based on Non-MTUS Citation ODG; Opioid Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen, Page(s): 76-80, 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of Hydrocodone/Acetaminophen (Norco) for moderate to moderately severe pain on an

as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling both acute and chronic pain. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guideline criteria have been met for the post-operative use of Norco. Therefore, this request is medically necessary.

Pre-op; H&P, CXR, EKG, Labs: CMP, CBC, Lipid panel, PT, PTT: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Routine pre-operative chest radiographs are not recommended for a patient of this age except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. The 7/17/14 utilization review modified and approved this request for pre-op H&P, comprehensive metabolic panel, complete blood count, lipid panel, prothrombin time, and partial thromboplastin time. Chest x-ray and EKG were denied based on age. Given the risks of undergoing anesthesia and associated medical necessity supporting lipid testing, the requests for chest x-ray and EKG are established. Therefore, this request is medically necessary.

Urinalysis: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary

for routine procedures unless a specific indication is present. Guidelines criteria have been met. The use of the requested pre-op lab urinalysis appears reasonable in a 28-year-old patient undergoing general anesthesia. Therefore, this request is medically necessary.

Ibuprofen 800mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; NSAIDs. Decision based on Non-MTUS Citation ODG; NSAIDS

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 264, 271.

Decision rationale: The California MTUS guidelines recommend the use of non-steroidal anti-inflammatory drugs, like ibuprofen, in the management of acute pain in forearm, wrist & hand complaints. Guideline criteria have been met for post-operative use of this medication. Therefore, this request is medically necessary.

Micro Glove plus supplies x3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines regarding TENS, post operative pain (transcutaneous electrical ner.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): 114-121.

Decision rationale: The Micro Z glove is an electro-mesh garment electrode designed to be used with a high-volt pulsed galvanic neuromuscular stimulator. The California MTUS guidelines for transcutaneous electrotherapy consider galvanic stimulation investigational for all indications. Guidelines state that TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guideline criteria have not been met. There is no evidence to support the use of galvanic stimulation for this or any indication. The 7/17/14 utilization review modified this request and allowed a 30-day trial of this device as a TENS unit. There is no compelling reason to support the medical necessity of this unit beyond the prior modification. Therefore, this request is not medically necessary.