Case Number:	CM14-0086218		
Date Assigned:	07/23/2014	**Date of Injury:**	03/19/2010
Decision Date:	09/24/2014	**UR Denial Date:**	05/28/2014
Priority:	Standard	**Application Received:**	06/09/2014

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 Plastic and Reconstructive Surgery and is licensed to practice in Virginia, Maryland, and North Carolina. 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:

The patient is a 44 year old female with a reported date of injury on 3/19/10 who requested authorization for right wrist arthroscopy and debridement with Extensor Pollicis Longus (EPL) transposition followed by post-surgical physical therapy for 12 visits. She had previously undergone right cubital tunnel release on 10/9/13 followed by physical therapy. On 12/17/13 she was noted to have a painful 'popping' with wrist extension and flexion, likely a 'trigger wrist' as the result of a 2011 surgery. Her activity had been modified; she was taking non-steroidal anti-inflammatory drugs (NSAIDs) and was continuing with hand therapy. Progress note dated 1/7/14 documents continued audible popping of the wrist and tender scaphotrapezotrapezoidal (STT) joint area. Stabilization of the carpometacarpal (CMC) joint of the thumb stops the popping. Finkelstein's test is negative. X-rays were performed that were stated to be normal. MRI of the right thumb was requested to evaluate for possible instability vs tenosynovitis vs STT tear. A hand-based thumb splint was recommended as was continued hand therapy and activity restrictions. Documentation from follow-up on 2/4/14 notes progressing painful popping of the right wrist that is audible and palpable. She has been undergoing bracing. An MRI of the wrist was again recommended, as well as an intra-articular injection. Casting was discussed as a possible treatment versus EPL transposition to correct the subluxation. MRI results from 2/20/14 performed for right wrist pain noted mild osteoarthritic changes of the 1st carpometacarpal joint and pisotriquetral joint and no intrinsic ligamentous tearing is seen. Follow-up from 2/25/14 notes continued pain with wrist/thumb popping. Casting versus surgical evaluation with a diagnostic right wrist arthroscopy and EPL transposition were considered. Recommendation was made for a second opinion. The patient was seen by a psychiatrist on 3/5/14, noting no evidence of secondary gain. The patient had previously been seen by a psychologist as well. Agreed medical examination dated 3/17/14 notes continued pain and a

popping sensation of the right wrist. Examination notes full range of motion of the fingers and wrist. The lunotriquetral shuck test produces pain. The scaphoid shift test is negative. The Distal Radio-Ulnar Joint (DRUJ) is moderately tender. She is tender throughout the radiocarpal joint, but there is no specific positive ligamentous provocative testing. Assessment is that of right wrist pain with loss of strength and non-specific synovitis. A clear etiology for the right wrist pain could not be given. Surgery was not recommended. A vigorous strengthening and home exercise program was recommended. Continued follow-up from 3/18/14 notes casting of the patient as well as hand therapy for strengthening and recommendation for a second opinion. Activity restrictions were placed. Documentation from follow-up on 4/1/14 notes the pain in her wrist is the main problem. She had had some relief from a diagnostic wrist injection, but the crepitus is still severe. The cast was replaced. Documentation from follow-up on 4/15/14 notes the cast was removed and the popping immediately returned. A second opinion dated April 25, 2014 notes the painful right wrist snapping. The tenderness is localized to the EPL overlying the second metacarpal base. Intra-articular wrist snapping or instability cannot be ruled out. Thus, EPL transposition and wrist arthroscopy is recommended. Documentation from 5/13/14 notes recommendation for surgical treatment to include right wrist arthroscopy and EPL transposition followed by hand therapy. Recommendation was also made to see a psychiatrist within network who accepts workmen's compensation. Utilization review dated 5/28/14 did not certify the procedures and post-operative therapy times 12 visits. Reasoning given was that there are 'limited objective findings' for a clear diagnosis to warrant right wrist surgery. Recommendations had been made for vigorous physical therapy for 3-4 months by AME as well as a psychiatric consult as noted from a later progress report. A subsequent utilization review dated 6/19/14 did certify the procedures and modified the post-operative physical therapy from 12 to 9 visits. Reasoning for certification was that there was a clear abnormal EPL finding on examination to warrant tendon transposition. The patient had received some temporary pain relief from a right wrist injection, suggesting an intra-articular etiologic source. Thus, a diagnostic wrist arthroscopy could help to clarify a diagnosis. The patient had failed conservative measures.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right wrist arthroscopy and debridement with ELP transposition: 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.

MAXIMUS 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 (ODG) Forearm, Wrist and Hand, Diagnostic Radiography; and Other Medical Treatment Guideline or Medical Evidence:Cift H, Ozkan K, Sylemez S, Ozkan FU, Cift HB. Ulnar-sided pain due to extensor carpi ulnaris tendon subluxation: a case report. Journal of Med Case Rep - 2012; (6); 394.

Decision rationale: The patient is a 44 year old female with a well-documented painful right wrist and apparent, reproducible subluxation of the right Extensor Pollicis Longus (EPL) tendon. Conservative measures that have been attempted are well documented. This includes bracing, casting, NSAIDs, injection, physical therapy and activity modifications. Radiographic studies have been non-diagnostic, but this does not rule out intra-articular pathology definitively. Specifically, EPL transposition is not addressed from ACOEM, but general surgical recommendations from page 270 are as follows: Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature Fail to respond to conservative management, including worksite modifications 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. The patient is well-documented to have loss of strength on the right side and progressive, non-resolving symptoms despite an extensive well-documented non-operative therapy. If there is subluxation/triggering of the EPL tendon then transposition/relocation of the tendon would be expected to surgically address the condition. Thus, EPL transposition would be consistent with ACOEM guidelines. As stated by the requesting physician, this is not a common condition. From the reference provided, there is some evidence that re-aligning an extensor tendon that has demonstrated subluxation is a reasonable surgical approach and may improve pain. This is also more common in a rheumatologic patient at the metacarpophalangeal joints. Improved hand mechanics is accomplished after surgical correction. With respect to arthroscopy, this is being used as a diagnostic tool initially. 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)The patient has negative imaging results, but has continued symptoms despite conservative treatment. Thus, diagnostic arthroscopy followed by debridement if necessary is consistent with ODG guidelines. The utilization review states that there are limited objective findings to warrant surgical intervention. However, that is the reason to perform a diagnostic arthroscopy, as outlined by ODG. If the patient has continued pain despite conservative management and negative results on imaging, diagnostic arthroscopy is indicated. This is the case for this patient. In addition, a previous right wrist injection provides support that the pain may be related to intra-articular pathology. Also, the utilization review states that review of the findings and recommendations from a requested psychiatric consult would be reasonable. However, the patient has been documented to have undergone psychiatric and psychological evaluation previously, with no evidence of secondary gain. Thus, the intent of the psychiatric evaluation appears to be for continued follow-up. In addition, other recommendations made by the AME include continued physical therapy and strengthening. This appears to have been satisfied as well, as the requesting surgeon continued to document recommendations of the AME and had tried other forms of conservative measures. Thus, based on the above rationale right wrist arthroscopy and EPL transposition is considered medically necessary.

Post-op physical therapy 12 visits for right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 206. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 19.

Decision rationale: As the surgeries were considered medically necessary, an initial course of physical therapy is medically necessary. Based on the following definition as stated in the postsurgical guidelines: Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations, the following are the surgical treatments that may be applicable depending on the intra-operative findings: Extensor tendon repair or tenolysis [DWC]:Postsurgical treatment: 18 visits over 4 months Postsurgical physical medicine treatment period: 6 months Extensor tenosynovectomy [DWC]:Postsurgical treatment: 14 visits over 3 months Postsurgical physical medicine treatment period: 6 months Synovitis and tenosynovitis (ICD9 727.0):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. Thus, based on these recommendations 18 visits over 4 months is reasonable. This would be consistent with an initial therapy of 9 visits. Further therapy would require specific documentation of functional improvement and medical necessity. Thus, a total of 12 visits would be outside the recommended allotment for initial postoperative therapy and should not be considered medically necessary.