

Case Number:	CM15-0171948		
Date Assigned:	09/14/2015	Date of Injury:	10/16/2013
Decision Date:	10/14/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/01/2015

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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand 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 58 year old female who sustained an industrial injury on 10-16-13. Of note, several documents within the submitted medical records are difficult to decipher. The injured worker reported left wrist discomfort. A review of the medical records indicates that the injured worker is undergoing treatments for left wrist sprain, lumbar spine strain sprain. Medical records dated 7-30-15 indicate pain rated at 6 to 7 out of 10. Provider documentation dated 7-30-15 noted the work status as return to modified work on 7-30-15 noting work restrictions. Treatment has included diclofenac since at least February of 2015, Flurbiprofen since at least February of 2015, Prilosec since at least February of 2015, left wrist injection (7-9-15), physical therapy, Norco since at least August of 2014, Lyrica since at least August of 2014 and Advil since at least August of 2014. Objective findings dated 7-30-15 were illegible. The original utilization review (8-13-15) denied a request for left De Quervain's release with possible tenosynovectomy/ tenolysis, Pre-operative medical evaluation, Initial post-operative physical therapy 8 sessions, Associated surgical services; Continuous cold therapy unit purchase, and Associated surgical services; Ultracin lotion 120 milliliters.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left De Quervain's release with possible tenosynovectomy/tanalysis: Overturned

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.

Decision rationale: Per the ACOEM guidelines, Chapter 11, page 266, DeQuervain's tendinitis, if not severe, may be treated with a wrist-and-thumb splint and acetaminophen, then NSAIDs, if tolerated, for four weeks before a corticosteroid injection is considered. Per the ACOEM guidelines, Chapter 11, page 271, "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." This patient has failed conservative treatment for several months with a steroid injection, NSAIDs and splinting. Release is medically necessary.

Pre-operative medical evaluation: 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-TWC, Low Back updated 5/15/15.

Decision rationale: ODG-TWC, Low Back updated 5/15/15 states: Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those, undergoing intermediate-risk surgeries that have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing (Feely, 2013). Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if

there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown (AHRQ, 2013). The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing. There is insufficient evidence to support routine preoperative medical clearance prior to straightforward hand surgery procedures. Dequervains release is a straightforward procedure, and the records do not document any medical issues. The hand surgeon can perform a history and physical and refer the patient for preoperative clearance if the history and physical detects any medical issues. The request is not medically necessary.

Initial post-operative physical therapy 8 sessions: Overturned

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

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

Decision rationale: Per MTUS: Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04): Postsurgical treatment recommends 14 visits over 12 weeks. Postsurgical physical medicine treatment period is: 6 months. The MTUS guidelines allow up to 14 visits following deQuervains release. The request for eight sessions is consistent with the guidelines. The request is medically necessary.

Associated surgical services; Continuous cold therapy unit; purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods.

Decision rationale: California MTUS ACOEM Forearm, Wrist, and Hand Complaints, page 265, ODG Forearm, Wrist, and Hand, and California Medical Treatment Utilization Schedule (MTUS), 2009, American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Second Edition, 2004, Forearm, Wrist, and Hand Complaints, page 265 indicate, 'patients' at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. This patient can use cold packs following surgery. A continuous cooling device is not required. The request is not medically necessary.

Associated surgical services; Ultracin lotion 120ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per MTUS: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ultracin contains METHYL SALICYLATE (28%), MENTHOL (10%), and CAPSAICIN (0.025%). MTUS does not recommend menthol as a topical agent, and therefore the compounded product is not medically necessary.