

Case Number:	CM15-0172155		
Date Assigned:	09/14/2015	Date of Injury:	01/23/2001
Decision Date:	10/21/2015	UR Denial Date:	08/20/2015
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(n) 66 year old female, who sustained an industrial injury on 1-23-01. The injured worker was diagnosed as having bilateral De Quervain's tenosynovitis, status post right carpal tunnel release in 1-2014 with recurrent carpal tunnel syndrome, right upper extremity chronic regional pain syndrome and hypertension. The physical exam (2-24-15 through 5-18-15) revealed wrist flexion was 43-44 degrees, extension was 42 degrees, radial deviation was 18 degrees and ulnar deviation was 27-28 degrees. There was also a positive Tinel's sign and decreased sensation along the second and fourth digits of the right hand. Treatment to date has included an EMG-NCV study in 3-2015. As of the PR2 dated 7-14-15, the injured worker reports left thumb discomfort and dropping things. Objective findings include a positive Tinel's and Phalen's test, wrist flexion is 50 degrees, extension is 50 degrees, radial deviation is 12 degrees and ulnar deviation is 20 degrees. There is also tenderness to palpation over the left greater than right flexor and extensor tendons and first carpometacarpal joints. The treating physician requested a left De Quervain's release with possible tenosynovectomy-tenolysis, carpal tunnel release with possible flexor tenosynovectomy and or median neurolysis, pre-op medical clearance evaluation, post-op physical therapy 2 x 4 and a continuous cold therapy unit (purchase). On 7-14-15 the treating physician requested a Utilization Review for a left De Quervain's release with possible tenosynovectomy-tenolysis, carpal tunnel release with possible flexor tenosynovectomy and or median neurolysis, pre-op medical clearance evaluation, post-op physical therapy 2 x 4 and a continuous cold therapy unit (purchase). The Utilization Review dated 8-20-15, non-certified the request for a left De Quervain's release with possible

tenosynovectomy-tenolysis, carpal tunnel release with possible flexor tenosynovectomy and or median neurolysis, pre-op medical clearance evaluation, post-op physical therapy 2 x 4 and a continuous cold therapy unit (purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Left DeQuervains release with possible tenosynovectomy/tenolysis: Overturned

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): 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 and splinting. Release is medically necessary.

Carpal tunnel release with possible flexor tenosynovectomy and or median neurolysis: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Plast Reconstr Surg. 1978 Jan; 61 (1): 93-6. The effect of various adjuncts on the surgical treatment of carpal tunnel syndrome secondary to chronic tenosynovitis. Freshwater MF, Arons MS. J Hand Surg Am. 1991 Mar; 16 (2): 211-8. Internal neurolysis fails to improve the results of primary carpal tunnel decompression. Mackinnon SE1, McCabe S, Murray JF, Szalai JP, Kelly L, Novak C, Kin B, Burke GM. Clin Orthop Relat Res. 1988 Feb; 227: 251-4. Interfascicular neurolysis in the severe carpal tunnel syndrome. A prospective, randomized, double-blind, controlled study. Lowry WE Jr1, Follender AB.

Decision rationale: According to a study by Freshwater and Arons, "A series of 22 patients with carpal tunnel syndrome secondary to chronic tenosynovitis was divided into two groups. The first group was treated by transverse carpal ligament release alone. The second group was treated by transverse carpal ligament release, external neurolysis of the median nerve, flexor

synovectomy, and intraoperative corticosteroid instillation. Both groups were comparable preoperatively as to symptoms, signs, and electrophysiological data. At two years postoperatively there were no statistically significant differences in the symptoms, signs, and electrophysiological data in the two groups. The only difference was that patients undergoing release alone were able to return to work earlier than those patients who had the adjunctive procedures." Lowry et al and MacKinnon et al found no benefit to internal neurolysis for the treatment of severe carpal tunnel syndrome. There is no evidence that tenosynovectomy or neurolysis will improve the outcomes of carpal tunnel release. These additional interventions are not medically necessary. Because tenosynovectomy and neurolysis are denied, the request is not medically necessary.

Pre-op medical clearance evaluation: Upheld

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 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 surgery who 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. 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, therefore the requested treatment is not medically necessary.

Post-op physical therapy 2x4: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

Decision rationale: DeQuervain's release is approved. Therapy will be required following surgery for recovery. Per MTUS: Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04): Postsurgical treatment: 14 visits over 12 weeks. Postsurgical physical medicine treatment period: 6 months. The request for 8 visits is consistent with MTUS guidelines and is medically necessary.

Continuous cold therapy unit (purchase): Upheld

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

Decision rationale: Per the California MTUS ACOEM Forearm, Wrist, and Hand Complaints, page 265, "patients' at home applications of heat or cold packs may be used before or alter exercises and are as effective as those performed by a therapist." The patient can use a cold pack following surgery for pain and swelling management. Therefore this request is not medically necessary.