

<b>Case Number:</b>	CM15-0175811		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	12/30/2014
<b>Decision Date:</b>	10/19/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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 65 year old male who sustained an industrial injury on 12-30-2014. Current diagnoses include radio carpal osteoarthritis and distal radioulnar joint osteoarthritis. Report dated 08-11-2015 noted that the injured worker presented with complaints that included left wrist pain. Pain level was 5 (constant) and 9 (intermittent) out of 10 on a visual analog scale (VAS). Physical examination performed on 08-11-2015 revealed tenderness over the proximal wrist, primarily centered over the ulnar surface, and range of motion is limited. Previous diagnostic studies included x-rays and MRI (report included). Previous treatments included medications, physical therapy, 5 cortisone injections, home exercises, and bracing. The treatment plan included recommendation for an AIN PIN neurotomy for pain control. The utilization review dated 08-24-2015, non-certified the request for left wrist anterior and posterior interosseous neurectomy (AIN-PIN), and post-operative physical therapy x12.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left wrist anterior and posterior interosseous neurectomy (AIN/PIN): 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 Osteoarthritis of the Wrist. Cayci, Cenk; Carlsen, Brian T. Plastic & Reconstructive Surgery. 133(3): 605-615, March 2014.

**Decision rationale:** The patient is a 65-year-old male with chronic left wrist pain associated with radio carpal osteoarthritis and distal radioulnar joint osteoarthritis. He has undergone extensive conservative management including physical therapy, multiple steroid injections, medical management, splinting and home exercises. His diagnosis is supported by radiographic studies. A AIN/PIN neurectomy was recommended prior to any significant surgical treatment. ACOEM does not specifically address the requested neurectomies. However, from the above reference, this can be a successful treatment. However, they state, 'Before proceeding with neurectomy, the patient should undergo a trial, whereby both the anterior and posterior interosseous nerves are injected with a trial of a long-acting anesthetic. This allows the patient a period of hours after the injection to assess the level of relief that may be expected from the denervation procedure, and an improvement in grip strength can be assessed in the surgeon's office.' Based on the supplied documentation, from the previous injections, it is not clear if the AIN and PIN were specifically injected. Therefore, the procedure should not be considered medically necessary until this is clarified or performed/documented.

**Post operative therapy x 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** As the procedure was not considered medically necessary, postoperative therapy would not be necessary.