

Case Number:	CM15-0177663		
Date Assigned:	09/29/2015	Date of Injury:	11/26/2013
Decision Date:	11/10/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/09/2015

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 27 year old female, who sustained an industrial injury on November 26, 2013, incurring left wrist and left hand injuries. She was diagnosed with left de Quervain's synovitis, intersection syndrome and left extensor tendon synovitis. Treatment included MRA, Magnetic Resonance Imaging, rest, bracing, heat, cold application, home exercise program, physical therapy, work restrictions, and steroid injections without any pain relief. Currently, the injured worker complained of increased left hand pain with numbness and tingling occurring mostly at night. She rated her pain 6-7 out of 10 on a pain scale from 1 to 10. Upon examination, she was noted to have increased tenderness of the left wrist and hand. She was unable to grip with the left hand. Her pain was made better with stretching and worse with activity, use and typing. Flnklestein's test was noted to be positive. The treatment plan that was requested for authorization on September 9, 2015, included left De Quervain's release, short arm splint, eight occupational therapy visits, pre-operative appointment, medical clearance and an assistant surgeon. On August 27, 2015, a request for surgical authorization, arm splint, occupational therapy, re-op appointment, medical clearance and assistant surgeon was non-certified by utilization review.

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: 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 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. The patient has persistent symptoms despite three steroid injections. Surgery is indicated. The request is medically necessary.

Associated Surgical Service: Short Arm Splint: 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): Initial Care.

Decision rationale: Per ACOEM, Chapter 11, page 264: Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. A splint is appropriate as part of postoperative rehabilitation following the DeQuervain's surgery. The request is medically necessary.

Associated Surgical Service: 8 Occupational Therapy Visits: 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 page 21: 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 for rehabilitation following DeQuervain's release is medically necessary. The patient will require OT to regain function. The request is medically necessary.

Pre-op appointment: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Preoperative testing.

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: Per ODG: "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." A pre-op appointment for history and physical prior to surgery is appropriate and medically necessary.

Associated surgical service: Medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Preoperative testing.

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, and 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. The request is not medically necessary.

Assistant surgeon: 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 Mymensingh Med J. 2015 Apr;24(2):341-5. Surgical Decompression of Resistant Cases of DeQuervain's Disease. Haque MM1, Datta NK, Faisal MA, Islam A, Uddin MJ, Tarik MM, Hossain MA.

Decision rationale: First compartment release is a straightforward hand surgery procedure that takes 30 minutes or less to complete. An assistant surgeon is not required for straightforward hand surgery procedures.