

<b>Case Number:</b>	CM13-0051061		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/26/2011
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2013

### 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 Orthopedic Surgery, has a subspecialty in Spine Fellowship and is licensed to practice in California. 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 injured worker has filed a claim for carpal tunnel syndrome associated with an industrial injury date of May 26, 2011. Treatment to date has included physical therapy. Utilization review from November 7, 2013 modified the request for left hand carpal tunnel release open, proximal flexor tendon sheath incision left finger, and left elbow ulnar neuroplasty and epicondylectomy. The medical records from 2013 were reviewed showing the patient complaining of pain and numbness in the hands, left worse than right. There is noted loss of grip strength and weakness in the left hand. There is also pain in the left elbow. Physical exam demonstrated positive Phalen's test and positive Tinel's test. Electrodiagnostics noted bilateral carpal tunnel syndrome, left greater than the right, and bilateral cubital tunnel syndrome. The left little finger also had triggering. Medical records from 2013 were reviewed showing the patient complaining of pain and numbness in the hands, left worse than right. There is noted loss of grip strength and weakness in the left hand. There is also pain in the left elbow. Physical exam demonstrated positive Phalen's test and positive Tinel's test. Electrodiagnostics noted bilateral carpal tunnel syndrome, left greater than the right, and bilateral cubital tunnel syndrome. The left little finger also had triggering.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT HAND CARPAL TUNNEL RELEASE OPEN, PROXIMAL FLEXOR TENDON SHEATH INCISION LEFT FINGER, AND LEFT ELBOW ULNAR NEUROPLASTY AND EPICONDYLECTOMY: 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-TWC), Elbow Procedure, Carpal Tunnel Syndrome Procedure, and Indications for Surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): ) Chapter 11 pages 263-265, 271, Elbow Disorders Chapter, pages 603-606.

**Decision rationale:** As stated on pages 263-265 in the California MTUS ACOEM 2nd Edition 2004, Chapter 11, carpal tunnel release is indicated on failure of initial conservative treatment consisting of 3 of the following: Activity modification, wrist splinting, nonprescription analgesia, and exercise training, and/or successful initial outcome from steroid injection trial. As stated on pages 603-606 in the California MTUS ACOEM Elbow Disorders Chapter, cubital tunnel release is indicated for failure of at least 3-6 months of conservative care given evidence of clinical and electrophysiological findings. As stated on pages 271 in the California MTUS ACOEM 2nd Edition 2004, Chapter 11, trigger fingers are treated with lidocaine and corticosteroid injection into or near the thickened area of the flexor tendon sheath of the affected finger and are almost always sufficient her symptoms and restore function. A local procedure may be necessary to permanently correct with persistent triggering. In this case, the patient is noted to have carpal tunnel syndrome, cubital tunnel syndrome, and trigger finger based on history, physical exam, and electrodiagnostic studies. Conservative treatment for the carpal tunnel syndrome and cubital tunnel syndrome were not clearly documented; there were no mentions of splinting, activity modification, etc. It is unclear whether the patient received steroid and anesthetic injections for the trigger finger or a local procedure. Given the insufficient documentation for conservative therapy, the request for Left Hand Carpal Tunnel Release Open, Proximal Flexor Tendon Sheath Incision Left Finger, and Left Elbow Ulnar Neuroplasty and Epicondylectomy Is not medically necessary.

**POST OPERATIVE OCCUPATIONAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The requested surgical procedure has been deemed not medically necessary. Hence, the dependent request for Post Operative Occupational Therapy Three (3) Times A Week For Four (4) Weeks is not medically necessary.