

Case Number:	CM14-0005496		
Date Assigned:	01/24/2014	Date of Injury:	10/22/2007
Decision Date:	06/20/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/15/2014

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 Occupational Medicine 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 patient is a 53-year-old female who has submitted a claim for right carpal tunnel syndrome associated with flexor tendon tenosynovitis as well as first dorsal compartment tendonitis (De Quervain's Syndrome) associated with primary and posttraumatic arthritis of the trapezium-first metacarpal joint associated with an industrial injury date of October 22, 2007. Medical records from 2012 to 2013 were reviewed. The patient complained of persistent neck pain radiating to both hands, associated with numbness and tingling sensation. She likewise complained of constant pain at the right wrist, located primarily at the first digit. There was sharp shooting pain to the dorsal aspect of both hands. The patient does not smoke. Physical examination of the right wrist revealed tenderness at the palm, radial side of the wrist, and trapezium first metacarpal phalangeal joint. The patient was able to make a fist and extend the fingers without difficulty. The radial pulse was present but not strong. The short thumb abductor, wrist extensors, and first dorsal interosseous muscle demonstrated moderate to severe grade 4 weakness. Finkelstein's, Tinel's, carpal compression, and Phalen's tests were positive. Deep tendon reflexes were trace at the biceps, but unobtainable at the triceps and brachioradialis. MRI of the cervical spine, dated April 20, 2012, noted several levels of neural foraminal stenoses at the C5-C6 and C7 to T1 levels. The most significant damage appeared to be at the C5 to C6 secondary to central canal stenosis with flattening of the dural sac. EMG/NCV report, dated September 26, 2013, demonstrated right median neuropathy at the wrist, as well as, borderline left median neuropathy at the wrist, and a chronic right C6 nerve root impingement. The treatment to date has included left carpal tunnel release, cervical epidural injection, use of thumb splint, and medications such as Voltaren gel, Ultram, and Tylenol. The utilization review from December 18, 2013 denied the requests for right complex flexor tendon tenosynovectomy, right median nerve neurolysis, right first dorsal compartment tenovagotomy because these are not supported by the literature.

There was no failure of conservative management of De Quervain's tenosynovitis prior to recommending surgery. Furthermore, there was no information on prior conservative management of De Quervain's tenosynovitis. The request for post operative physical therapy x 12 was modified into 4 sessions as recommended by the guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT COMPLETE FLEXOR TENDON TENOSYNOVECTOMY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hand Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Role of Flexor Tenosynovectomy in the Operative Treatment of Carpal Tunnel Syndrome, The Journal of Bone and Joint Surgery 2002, Feb; 84-A(2):221-5 (<http://www.jbjs.org/content/84/2/221.long>)

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, The Journal of Bone and Joint Surgery 2002 was used instead. It states that there was neither an added benefit nor an increased rate of morbidity in association with the performance of a flexor tenosynovectomy at the time of carpal tunnel release. There were no clinical correlations that might predict which individuals would benefit from flexor tenosynovectomy on the basis of either the gross (intraoperative) or histologic evaluation of the flexor tenosynovium. Routine flexor tenosynovectomy offers no benefit compared with sectioning of the transverse carpal ligament alone for the treatment of idiopathic carpal tunnel syndrome. In this case, utilization review, dated December 18, 2013, certified the request for right carpal tunnel release. There is no discussion concerning the need to perform flexor tendon synovectomy as adjunct to carpal tunnel release. The guidelines do not recommend it due to no added beneficial effects. Therefore, the request for right complete flexor tendon tenosynovectomy is not medically necessary.

RIGHT MEDIAN NERVE NEUROLYSIS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hand Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Internal Neurolysis Fails to Improve the Results of Primary Carpal Tunnel Decompression, Journal of Hand Surgery 1991 Mar; 16(2):211-8 (<http://www.ncbi.nlm.nih.gov/pubmed/2022828#>)

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, The Journal of Hand Surgery was used instead. It states

that there is no statistical difference in terms of improvement in hand sensibility testing, thenar muscle strength, and atrophy between decompression of the transverse carpal ligament and the addition of an internal neurolysis of the median nerve. The addition of an internal neurolysis to division of the transverse carpal ligament does not add significant improvement in the sensory or motor outcome of patients with primary carpal tunnel syndrome. In this case, utilization review, dated December 18, 2013, certified the request for right carpal tunnel release. There is no discussion concerning the need to perform neurolysis as adjunct to carpal tunnel release. The guidelines do not recommend it due to no added beneficial effects. Therefore, the request for right median nerve neurolysis is not medically necessary.

RIGHT FIRST DORSAL COMPARTMENT TENOVAGINOTOMY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hand Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless' Textbook of Orthopaedics, DeQuervain's Disease (http://www.wheellesonline.com/ortho/dequervains_disease)

Decision rationale: The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Wheelless' Textbook of Orthopaedics was used instead. It states that DeQuervain's Disease is an inflammation that causes thickening and stenosis of synovial sheath of first compartment with pain during tendon movement. Non-operative treatment includes thumb spica splint and steroid injection. Surgical treatment includes decompression of the first dorsal compartment. In this case, patient has been diagnosed with first dorsal compartment tendonitis (De Quervain's Syndrome) manifested by persistent right wrist pain, located primarily at the first digit. The short thumb abductor, wrist extensors, and first dorsal interosseous muscle demonstrated moderate to severe grade 4 weakness. The patient was given thumb splint, however, without improvement of symptoms. The patient was then recommended to undergo surgery, however, it is unclear if all forms of conservative management have been exhausted. There is no evidence that the patient underwent steroid injection, part of non-operative treatment for tendonitis. The guidelines advocate repeated steroid injections prior recommending surgery. The guideline criteria were not met. Therefore, the request for right first dorsal compartment tenovagotomy is not medically necessary.

POST OPERATIVE PHYSICAL THERAPY X 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16-17.

Decision rationale: California MTUS Post-Surgical Treatment Guidelines recommend post-operative physical therapy of 3-8 sessions over 3 to 5 weeks for carpal tunnel release. In this case, utilization review, dated December 18, 2013, certified the request for right carpal tunnel

release. Physical medicine post-operatively is necessary to promote functional recovery, however, the present request of 12 sessions exceed the guideline recommendation of 3 to 8 sessions. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for post operative physical therapy x 12 is not medically necessary.