

<b>Case Number:</b>	CM14-0013111		
<b>Date Assigned:</b>	02/24/2014	<b>Date of Injury:</b>	02/12/2013
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 Orthopedic surgery 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 claimant is a 47-year-old man who injured his right upper extremity on February 12, 2013 when he was shoveling and struck a rock. The records provided for review document a diagnosis of right carpal tunnel syndrome. The report of electrodiagnostic studies performed on September 04, 2013 was suggestive of mild carpal tunnel syndrome. The report of an orthopedic evaluation on December 23, 2013 described numbness of the hand and documented that a recent injection to the carpal tunnel did not provide long-term benefit. Physical exam showed a positive Tinel's and Phalen's testing, positive carpal tunnel compression testing and diminished two-point discrimination. A second injection of the carpal tunnel was given. It was documented that conservative treatment had failed and a right carpal tunnel release was recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT OPEN CARPEL TUNNEL RELEASE:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 270.

**Decision rationale:** Based on the California ACOEM Guidelines, the request for right carpal tunnel release would be medically necessary. The medical records document that the claimant

has mildly positive electrodiagnostic studies, has failed conservative care, and has positive physical examination findings. The ACOEM Guidelines recommend a carpal tunnel release in the setting of positive electrodiagnostic studies and examination findings. Therefore, the proposed surgery for carpal tunnel release is medically necessary.

**POST-OPERATIVE PHYSICAL THERAPY TWO TIMES PER MONTH (4 VISITS):**

Overtured

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

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

**Decision rationale:** The California MTUS Postsurgical Rehabilitative Guidelines also would support the role of four sessions of physical therapy. The Postsurgical Guidelines recommend three to eight sessions of physical therapy in the postoperative setting over a three-month period. The initial request of four sessions of therapy is medically necessary.

**HYDROCODONE 5/325MG (#30):** Overtured

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 79-80, 91.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend the use of hydrocodone. The need for operative intervention in this case has been established. This would support the need of postoperative short acting narcotic analgesics for pain control. Therefore, the request is medically necessary.

**GLOVE:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2014 Updates: Carpal Tunnel Procedure, Gel-padded glove.

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this request. Based on the Official Disability Guidelines, a glove is not recommended. The Official Disability Guidelines do not recommend the use of a gel glove because it has not been proven to provide a positive beneficial effect in either treatment or postoperative care of carpal tunnel release procedures. Therefore, the request for a glove is not medically necessary.

**PUTTY:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: carpal tunnel procedure, Exercises.

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this request. Based on the Official Disability Guidelines, the request for use of putty would not be indicated. While postoperative exercises are recommended, there is no indication for the use of putty as part of the exercises or why the physical therapy exercises prescribed would not be of benefit alone. The request is not medically necessary.

**SCAR GEL:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cochrane Database System Rev. 2013 Sep 12; Silicone gel sheeting for preventing and treating hypertrophic and keloid scars.

**Decision rationale:** The California MTUS and ACOEM Guidelines do address this request. Based on the peer-reviewed orthopedic literature Cochrane database, the request for scar gel is not recommended as medically necessary. Scar gel is typically not recommended for postoperative use following orthopedic procedures. The clinical records provided for review do not contain any indication that the claimant has a history or is at risk for keloid development. There is also no documentation to determine why additional treatment other than primary wound closure alone would be necessary for this claimant. Therefore, the request for scar gel is not medically necessary.