

<b>Case Number:</b>	CM14-0124098		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	02/18/2014
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	07/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Plastic and Reconstructive and is licensed to practice in Maryland North Carolina and Virginia. 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 50 year old female with a history of diabetes and a reported date of injury on 2/18/14 who requested authorization for right carpal tunnel release and De Quervains' release. Documentation from 8/26/14 notes the patient is seen with 'much discomfort in the hand and numbness into the 1st 3 digits. The discomfort is so bad that she is not working. Examination notes negative Tinel's, Positive Phalen's sign. There is numbness in the 1st 3 digits. She is tender at the 1st extensor compartment with positive Finkelstein's test. The right carpal tunnel and right 1st extensor compartment both were injected with Marcaine and triamcinolone. Will see if this helps her symptoms and will follow-up in 3 weeks. Documentation from September 2014 notes 'shots not helping', right carpal tunnel syndrome (CTS) and De Quervains' release, positive Finkelstein's, positive Tinel's and positive Phalen's. Will request surgery again, not working. Documentation from 7/21/14 notes the patient is seen for right wrist tendonitis and carpal tunnel syndrome. Hand surgery was recommended. Medication list includes Ibuprofen, Insulin, Warfarin and other unknown medications. She has been placed on work restrictions due to pain. Examination notes tender to right abductor pollicis longus with positive Finkelstein's sign, numbness of the right thumb, index and long finger with decreased grip strength. Treatment includes continue current plan, work restrictions and transfer of care to hand surgery. Documentation from 7/16/14 notes the patient is seen for right wrist pain. Tendonitis is improved, but patient had carpal tunnel syndrome on electrodiagnostic studies. 'Pt says hand Ortho wants to get authorization for her to have hand surgery. She says both her tendonitis and carpal tunnel need surgery. She feels like her hand is worse. When she works she gets numbness and pain right away.' Examination notes Finkelstein's positive on the right and negative Tinel's but complains of near constant numbness and pain to her fingers. Recommendations are made for work restrictions and transfer of care to hand ortho.

Documentation from 7/10/14 notes the patient has developed some swelling of the right hand, some tendonitis over the radial aspect, some numbness into the hand. She tried ibuprofen and splinting. It does wake her up at night with pain and numbness in the hand. She is on Coumadin for atrial fibrillation and cannot take non-steroidal anti-inflammatory medicines. She had nerve conduction studies at [REDACTED] that did show carpal tunnel syndrome. Examination notes the right wrist is tender at the 1st extensor compartment, positive Finkelstein's test, negative Tinel's, positive Phalen's test and some numbness in the 1st 3 digits, median nerve distribution. The patient is diagnosed with Right carpal tunnel syndrome and Right DeQuervain's tenosynovitis. I do think she has tried conservative therapy, and she continues to have symptoms. Recommendation is made for both right carpal tunnel release and release of the DeQuervain's tenosynovitis. Documentation from 7/2/14 notes the patient complains of right wrist and hand pain. The patient has hand pain and numbness and EMG/NCV showed carpal tunnel syndrome. Minor use of the hand causes pain and numbness. Examination notes negative Finkelstein's, positive Phalen's and numbness to middle finger of right hand. Recommendation is for 'Get PT, hand ortho consult and full duty.' Documentation from 6/18/14 notes the patient is seen for right wrist and hand pain. She was supposed to get physical therapy (PT) from a new location. She has median nerve neuropathy on electrodiagnostic studies. She continues with numbness and pain in her wrist and hand. She complains of some pain radiating from her neck but Electromyogram (EMG) and Nerve Conduction Studies (NCV) did not show evidence of cervical radiculopathy. Examination notes slight tenderness to right abductor pollicis longus with no limitation to ROM or use of thumb. Tinel's and Finkelstein's signs are negative, but complains of numbness to median nerve of right hand. Plan is for referral to hand surgery and continue physical therapy. Documentation from 6/4/14 notes the patient is still with numbness and tingling along with weakness of the right hand and wrist. She is not taking any pain medications. Examination notes right grip is weak with tingling down to the wrist and fingers. Plan is for request of PT, neuro referral and regular duty. Documentation from 5/23/14 notes the patient complains of numbness of the right hand. She had nerve conduction studies and found median nerve deficit, consistent with her symptoms. Examination notes right hand motor and intrinsic are normal. She has sensory numbness on the entire palmar aspect, without ulnar sparing. Plan is for possible referral with pt., but she feels it may be getting better. Electrodiagnostic studies from 5/7/14 note findings of moderate mononeuropathic process involving the right median nerve at or distal to the wrist. There are positive EMG findings in the abductor pollicis brevis. In the evaluation, the patient is noted to have tried bracing at night with only modest improvements. She has difficulty sleeping and handling objects. Documentation from 5/7/14 notes the patient is seen in follow-up of right wrist tendonitis and numbness. She is still getting numbness but no real pain except with excessive use. There is a change in PT location. She has not yet scheduled PT. Examination notes tender abductor pollicis longus with positive Finkelstein's and negative Tinel's at the wrist and positive Tinel's at the ulnar wrist. Recommendation is for electrodiagnostic studies and start PT at a new location. Physical therapy evaluation is noted on 3/26/14. Splinting of the right hand and forearm was documented with a thumb-spica splint. Previous documentation notes follow-up of right wrist injury and pain with probable De Quervain's tenosynovitis. She is documented to have been using a splint. She had begun non-steroidal anti-inflammatory drugs (NSAIDs) but was taken off due to current use of Warfarin. Utilization review dated 7/28/14 did not certify the procedures. Reasoning given was that a full course of conservative treatment was not documented including injections or

formal therapy. Submitted electrodiagnostic studies revealed essentially normal findings of the right wrist.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right carpal tunnel release and De Quervains' release.:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, DeQuervain's tenosynovitis.

**Decision rationale:** With respect to DeQuervain's tenosynovitis, the patient is documented to have signs and symptoms of this condition. She persistent pain consistent with this diagnosis and confirmed on physical examination with a positive Finkelstein's test. She has been well-documented to have attempted splinting, physical therapy, activity modification over a greater than 3 month period and recent injection that had failed. Her condition is noted to be worsening. This is well-documented to have affected her function as she is unable to work and has difficulty with general use of her right hand. From American College of Occupational and Environmental Medicine (ACOEM) p 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. From Official Disability Guidelines (ODG), surgery is recommended as an option if consistent symptoms, signs, and failed three months of conservative care with splinting and injection. de Quervain's disease causes inflammation of the tendons that control the thumb causing pain with thumb motion, swelling over the wrist, and a popping sensation. Surgical treatment of de Quervain's tenosynovitis or hand and wrist tendinitis/tenosynovitis without a trial of conservative therapy, including a work evaluation, is generally not indicated. The majority of patients with de Quervain'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 de Quervain's tendinitis. (AHRQ, 2003) (California, 1997) (Zarin, 2003) (Ta, 1999) Injection alone is the best therapeutic approach to de Quervain's tenosynovitis. (Richie, 2003) (Lane, 2001). As reasoned above, the patient has been treated over a greater than 3 month period with conservative management. This has affected her function and she has failed a steroid injection. The utilization review did not have access to the most recent evaluation documenting a steroid injection and its failure. The rest of the conservative management has been well-documented. Thus, De Quervain's release should be considered medically necessary.