

Case Number:	CM14-0170555		
Date Assigned:	10/20/2014	Date of Injury:	11/04/2010
Decision Date:	11/20/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/15/2014

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 Plastic & Reconstructive Surgery, and is licensed to practice in Maryland, Virginia & North Carolina. 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 27 year old male with a reported date of injury on 11/4/10 who had requested removal of the right thumb hardware following metatarsophalangeal (MCP) joint arthrodesis and right carpal tunnel release. Supplemental report dated 8/29/14 notes that the patient had previously undergone on 2/25/13 exploration of the radial and ulnar digital nerves, tenolysis of the flexor pollicis longus tendon, and arthrodesis of the right thumb metatarsophalangeal joint. He continues to complain of mild-to-moderate pain of the right thenar eminence, as well as some radiation into the forearm. He has a 'fuzzy' sensation down the radial aspect of the right thumb. He has previously undergone 2 explorations of the 1st web space and palmar thumb, without any evidence of abnormality. A nerve conduction study on 7/21/14 was reported as normal. Examination notes mild tenderness of the right thumb MCP joint. He has full flexion and extension of the thumb without evidence of triggering. He has normal sensation in the ulnar digital nerve distribution of the thumb but slight subjectively decreased sensation in the radial digital nerve distribution. He has a negative Tinel's signs but a positive Phalen's sign over the right carpal tunnel. He has slightly decreased sensation along the ring finger radial digital nerve as compared to the ulnar digital nerve. He has 4/5 muscle strength of the abductor pollicis brevis. The surgeon is suspicious that the patient may have an atypical carpal tunnel syndrome given his weakness, symptoms and physical examination findings. This may have occurred due to previous casting before and after repairing a collateral ligament. Even though his electrodiagnostic studies are normal, 15% of patients with carpal tunnel syndrome have normal studies. The right carpal tunnel was injected with steroid/Lidocaine. The patient can consider a carpal tunnel release at the time of plate removal following his previous MCP arthrodesis. Request for authorization is made on 9/10/14 for removal of implant deep, neuroplasty or transposition of median nerve at carpal tunnel, pre-op CXR, and labs: pt, ptt, cbc,

bmp, cmp. Agreed medical examination dated 4/8/14 notes the patient's previous history. Diagnoses are stated as ligament injury, right thumb, with subsequent fusion and neurolysis with possible complex regional pain syndrome and depression. He has had previous psychological evaluation and recommendation for treatment. His symptoms of his right hand affect his function and activities of daily living. He is stated to have reached maximal medical improvement. Qualified medical re-evaluation from psychiatry is noted from 10/10/14 and documents progress from psychiatric care. The patient may need treatment by a pain specialist for his chronic pain and may undergo hand surgery for hardware removal and right carpal tunnel release. Request for authorization is made for psychological treatment on 6/26/14. Qualified medical evaluation from psychiatry is noted from 4/14/14 and documents that the patient has depression and anxiety. Recommendation is made for a short-course of cognitive-behavioral therapy. Utilization review dated 9/17/14 did not certify removal of implant, neuroplasty or transposition of median nerve at the carpal tunnel. Reasoning given was that the diagnosis of carpal tunnel syndrome is not fully established by clinical. Also, purpose for hardware removal is not defined.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery: removal of implant: neuroplasty or transposition of median nerve at carpal tunnel release: 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); hardware removal

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm/wrist/hand, Surgery for hardware removal.

Decision rationale: The patient is a 27 year old male who had undergone multiple previous surgeries following an injury to the right thumb/hand. Based on sensory complaints, muscle weakness and sensory examination, right carpal tunnel release was requested. The patient has some symptoms and exam findings consistent with right carpal tunnel syndrome. However, he has some that do not, including a stated normal sensory exam of the ulnar side of the thumb. Sensory disturbances appear mild. In addition, he does not have supporting electrodiagnostic studies to confirm carpal tunnel syndrome. The patient was noted to have undergone a steroid injection to the right carpal tunnel; however, no follow-up evaluation was provided to document any response. Specific recent conservative management, including bracing and medical management has not been documented as recommended by ACOEM. With respect to carpal tunnel surgery, from ACOEM, page 270, surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is

undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). In summary, the patient has not had a clear diagnosis of right carpal syndrome supported by electrodiagnostic studies. Overall, the symptoms and clinical signs appear mild. He has a normal sensory examination of the ulnar thumb. Recent conservative management, including response to treatment, has not been adequately documented. Thus, based on this, carpal tunnel release should not be considered medically necessary. With respect to plate removal from the right thumb following arthrodesis, there is insufficient documentation related to the reasoning for this. The patient has some documentation of pain overlying the right thumb, but it is reported as mild and is not attributed to the plate. As documented in the utilization review, ODG guidelines do not recommend routine removal of hardware following fracture fixation, except for broken hardware or persistent pain after ruling out other sources of pain. Even though this was an arthrodesis, these guidelines would still apply. The hardware is noted to be internal plating and has been present since 2/25/13. No specific reasoning is given for its removal, thus it should not be considered medically necessary. If the surgeon considers that the hardware is the source of pain overlying the MCP joint, then this could be re-considered.

Associated surgical services: pre op chest x-ray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the procedures were not considered medically necessary, preoperative studies would not be necessary.

Associated surgical services: Labs (PT, PTT, CBC, BMP, CMP): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the procedures were not considered medically necessary, preoperative lab studies would not be necessary.