

Case Number:	CM14-0038521		
Date Assigned:	06/27/2014	Date of Injury:	09/11/2001
Decision Date:	07/31/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/02/2014

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 Surgery/Hand Surgery, and is licensed to practice in Oregon. 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 has been treated for chronic left hand median neuritis and has undergone multiple failed carpal tunnel releases. She has undergone three cervical spine surgeries for upper extremity symptoms with the last surgery completed in April 2012. She has also been treated for left long finger tendinitis. A 6/26/13 report by [REDACTED] states that the patient reported that numbness returned a few years previous, after she underwent carpal tunnel release. She also has a history of de Quervain's tendon release. An electromyography (EMG)/NCV (nerve conduction velocity) of the upper extremities from 1/16/12 was normal regarding the left median and ulnar nerves and was positive for left C7 (C8) cervical radiculopathy with active and chronic denervation. On 10/9/12, the patient underwent repeat electrodiagnostic studies with an indication of mild chronic multilevel mid cervical CS, C6, and C7 root pathology; superimposed ulnar nerve pathology manifested primarily by chronic neuropathic changes in the forearm and hand muscles innervated by the ulnar nerve; and superimposed left median motor nerve pathology manifested by chronic neuropathic changes in the left abductor pollicis brevis muscle. The patient underwent a left wrist MRI (magnetic resonance imaging) on 2/19/14 with the following findings: no acute findings including bone edema or ischemia, triangular fibrocartilage complex (TFCC) grossly intact, scapholunate and lunatotriquetral ligaments intact, normal collinear alignment, mild negative ulnar variance, and tiny ganglion-like cysts along the volar and medial aspects of the radiocarpal articulation. The patient was seen by [REDACTED] on 3/10/14 with continued complaints of left hand and wrist pain. The patient reported increased numbness in the left hand index finger, long finger, and thumb. She reported positive triggering of the left long finger. Examination revealed positive Finkelstein's, tenderness to palpation along the volar left long finger, positive triggering of the left long finger, positive Tinel's, positive Phalen's, and positive carpal compression test. The patient was provided the following

diagnoses: status post bilateral carpal tunnel releases, revision on the right; left carpal tunnel release with residual median nerve neuropathy; de Quervain's tenosynovitis of the left wrist; and bilateral flexor tendinitis, moderate to severe. There was no record of an EMG/NCV more recent than 10/9/12. The office had no records of previous steroid injections administered by their office to the left long finger.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for one (1) revision of left carpal tunnel release, A-1 pulley left long finger, first dorsal extensor tendon compartment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

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), Treatment for trigger fingers.

Decision rationale: The carpal tunnel release is not medically necessary. According to the ACOEM guidelines, surgical decompression of the median nerve usually relieves carpal tunnel syndrome (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. Trigger finger release is not medically necessary. According to the ACOEM guidelines, one or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. The Official Disability Guidelines (ODG) recommends steroid injections as the initial treatment for trigger fingers. According to the ODG, there is good evidence strongly supporting the use of local corticosteroid injections in the trigger finger. One or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. Steroid injection therapy should be the first-line treatment of trigger fingers in non-diabetic patients. Furthermore, per the ACOEM, 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. Surgery, however, carries similar risks and complications including the possibility of damage to the radial nerve at the wrist because it is in the area of the incision. In this case, the patient has already undergone carpal tunnel releases and has residual changes on her nerve conduction test. Nerve conduction tests often do not normalize after carpal tunnel release. Moreover, the patient has not had a NCV (nerve conduction velocity) more recent than 2012. The records do not document a steroid injection for the trigger finger. This patient has not failed conservative treatment for several months with steroid injections, non-steroidal anti-inflammatory drugs (NSAIDs) and splinting. As such, the request for one (1)

revision of left carpal tunnel release, A-1 pulley left long finger, first dorsal extensor tendon compartment is not medically necessary.

Prospective request for one (1) pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Surgery general information and ground rules, California Official Medical Fee Schedule, 1999 edition, pgs. 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation. An updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. (American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology*. 2012 Mar;116(3):522-38).

Decision rationale: According to the Practice advisory for preanesthesia evaluation, for selection and timing of preoperative tests may be ordered, required, or performed on a selective basis for purposes of guiding or optimizing perioperative management. The indications for such testing should be documented and based on information obtained from medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. In this case, since the primary procedure (one (1) revision of left carpal tunnel release, A-1 pulley left long finger, first dorsal extensor tendon compartment) is not medically necessary, none of the associated services (one (1) pre-operative medical clearance) is medically necessary.

Prospective request for twelve (12) post-op physical therapy sessions for the left wrist:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: The MTUS supports postoperative therapy following trigger finger release, carpal tunnel release and deQuervains release. However, since the primary procedure (one (1) revision of left carpal tunnel release, A-1 pulley left long finger, first dorsal extensor tendon compartment) is not medically necessary, none of the associated services (twelve (12) post-op physical therapy sessions for the left wrist) are medically necessary.