

<b>Case Number:</b>	CM14-0069259		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	07/17/2012
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2014

### 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 Surgery and is licensed to practice in Maryland, Virginia and 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 64 year old female with a reported date of injury on 7/17/12 due to repetitive tasks. The patient complains of pain and the inability to perform daily activities. She has stated that she has undergone physical therapy and steroid injections without success. Previous electrodiagnostic studies from 12/4/12 of the bilateral upper extremities report normal findings. On 7/25/13 the patient is noted to have undergone steroid injection of painful triggering of the left thumb and right middle finger. Documentation from 9/5/13 notes the patient has been using bracing at night and has been undergoing physical therapy. She complains of triggering and bilateral hand numbness and tingling. The progress report dated 9/10/13 notes the patient is going to physical therapy, MRI of the left hand has been ordered and she is not making much improvement. The examination notes left middle finger A1 catches as well as the right ring finger. Tinel's and Phalen's signs are positive bilaterally. The patient is to continue physical therapy and is noted that the patient is retired. An MRI of the left wrist from 9/26/13 notes that the patient has findings of degenerative/arthritis changes of the wrist, synovitis of the DRUJ/radiocarpal and mid-carpal joint and possible ganglion cyst and carpometacarpal (CMC) joint arthritis. Physical therapy visit from 10/11/13 notes that the 'wrists not bad and will probably DC next visit. The patient was discharged from physical therapy on 10/14/13 with a home exercise program. The progress report from 10/22/13 notes trigger fingers with surgery decision pending and carpal tunnel syndrome that will be observed for now. Request for authorization dated 11/19/13 notes diagnosis of left ulnar impaction syndrome, left carpal tunnel syndrome and left middle and ring finger trigger finger. Requests are made for surgical intervention. Documentation from 10/31/13 notes that the patient has positive Tinel's, positive direct compression, positive Phalen's for left median nerve involvement. The patient has crepitus and tenderness of the A-1 pulley of the left 3rd and 4th fingers. Impression is bilateral carpal

tunnel syndrome that is electrodiagnostically negative, bilateral trigger fingers of the thumb, index and middle fingers, left thumb CMC synovitis versus early degenerative joint disease, left ulnar impaction syndrome and possible triangular fibrocartilage complex (TFCC) tear. Recommendations are made for surgical intervention. Documentation from 12/17/13 notes the patient continues to have weakness and numbness in both her hands and triggering of her fingers. A1 pulley is thickened on both hands and Tinel's is positive. She is to continue hand splints and follow-up with hand surgeon. Documentation from 12/19/13 notes continued left wrist pain as well as numbness and tingling. Steroid injection was performed of the left carpal tunnel and left TFCC. Progress report on 1/29/14 notes marked improvement. Examination notes left wrist tinel positive, closes hand without catching, the right hand still triggers, tinel negative. Documentation from 1/30/14 notes pain on the left side is 1/10. She still reports occasional numbness and tingling in the right hand as well as the left hand. Examination reveals right middle and small finger crepitus and triggering and tenderness at the A-1 pulley. Negative Tinel, direct compression, Phalen's, right median nerve. Cortisone injection was provided to the right small and middle trigger fingers. Documentation from 3/12/14 notes no improvement from injection of the trigger fingers on the right. Documentation from 3/13/14 notes some improvement from the steroid injection but still triggers on the right side. The patient is noted to have increased left wrist pain due to care of her husband who is recovering from surgery. Documentation from 4/23/14 notes the patient's fingers are still triggering. Documentation from 4/24/14 notes continued right 3rd and 5th finger triggering. She has numbness and tingling in the right hand(radial three digits). There is right 3rd and 5th finger A-1 pulley crepitus but not active triggering. Right carpal tunnel exam negative Tinel's, positive direct compression, positive Phalen's. Recommendation was made for right endoscopic possible open carpal tunnel release and A-1 pulley release of the right 3rd and 5th digits.

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

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

**Right endoscopic possible open carpal tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, 270, 272.

**Decision rationale:** The patient is a 64 year old female with a well-documented history of bilateral hand numbness in the median nerve distribution supported by clinical exam findings that has persisted despite non-operative management of physical therapy and splinting. From the records, it does not appear she has had a steroid injection of the right carpal tunnel, just the left side. However, previous electrodiagnostic studies from 12/4/12 were reported as normal. As stated from ACOEM page 270, High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of carpal tunnel syndrome (CTS). Patients with the mildest symptoms display the poorest postsurgery 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. There has not been documentation of red flags of a serious nature, including but not limited to thenar atrophy which could help to diagnose a severe condition. Further, as stated from ACOEM page 261 with respect to carpal tunnel syndrome: Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. Thus, consideration for repeat electrodiagnostic studies is consistent with ACOEM, given that they were originally negative and her symptoms have persisted. In addition, as stated on page 272 Table 11-7, injection of steroid in mild to moderate cases of carpal tunnel syndrome is recommended after trial of splinting and medication. Thus, carpal tunnel release is not medically necessary at this time.

**A1 pulley release of right 3rd (middle) and 5th (small) fingers: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271, 273.

**Decision rationale:** The patient is noted to have continued painful triggering of the right 3rd and 5th digits despite conservative measures including steroid injections. From ACOEM, page 271 with respect to triggering, 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. A procedure under local anesthesia may be necessary to permanently correct persistent triggering. Further from page 273, table 11-7, surgical considerations are warranted after failure of non-operative management, which is present in this case. Thus, trigger release of the right 3rd and 5th digit is medically necessary.

**Post-OP occupational therapy 2 X 6=12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

**Decision rationale:** As trigger finger release was deemed medically necessary, post-surgical treatment is warranted. From post-surgical treatment guidelines, trigger finger (ICD9 727.03), postsurgical treatment is 9 visits over 8 weeks. Postsurgical physical medicine treatment period is 4 months. However, 12 visits exceeds the recommendation and would not be medically necessary. 9 visits would be consistent with the recommendations.

**Pre OP medical clearance:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back pain, preoperative testing, general.

**Decision rationale:** As the trigger finger release was deemed medically necessary and general anesthesia may be performed(although local anesthesia is an option), a preoperative medical clearance is consistent with the ODG, preoperative testing as follows, an alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. Thus, preoperative medical clearance is medically necessary.