

Case Number:	CM14-0027914		
Date Assigned:	06/16/2014	Date of Injury:	07/05/2011
Decision Date:	11/10/2015	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 64 year old male with a date of injury on 7-5-11. A review of the medical records indicates that the injured worker is undergoing treatment for bilateral hand and arm pain. Progress report dated 2-3-13 reports continued complaints of hand pain, left more than the right. He has elected to have surgery. Upon exam, he has positive thumb CMC grain bilaterally, he can bring his thumb over to the PIP joint of the small finger but not to the MP joint. He has positive Tinel's over the left carpal tunnel and negative over the right. Work status: modified work 3 days per week with limited repetitive use of his hand lifting 10-15 pounds. EMG and nerve conduction study of bilateral upper extremities (8-6-13) showed bilateral median neuropathy at the wrist mild to moderate worse on the left side. Request for authorization dated 2-13-14 made for outpatient left thumb ligament reconstruction tendon interposition left carpal tunnel release. Utilization review dated 2-21-14 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient left thumb ligament reconstruction tendon interposition: 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), Forearm, Wrist & Hand Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Trapeziectomy.

Decision rationale: The patient is a 64 year old male with signs and symptoms of left thumb CMC arthritis that has failed conservative management and is supportive by radiographic studies documenting a severe condition. Conservative management has included NSAIDs, bracing, physical therapy and failed steroid injection. Left thumb ligament reconstruction tendon interposition (LRTI) was recommended. ACOEM guidelines do not address this condition. From the ODG, Trapeziectomy is recommended among the different surgeries used to treat persistent pain and dysfunction at the base of the thumb from osteoarthritis, Trapeziectomy is safer and has fewer complications than the other procedures. Participants who underwent Trapeziectomy had 16% fewer adverse effects than the other commonly used procedures studied in this review; conversely, those who underwent Trapeziectomy with ligament reconstruction and tendon interposition had 11% more (including scar tenderness, tendon adhesion or rupture, sensory change, or Complex Regional Pain Syndrome Type 1). (Wajon, 2005) (Field, 2007) (Raven, 2006) Based on ODG and the medical documentation, surgical intervention appears medically necessary. However, as ODG recommends Trapeziectomy over other procedures including (LRTI), LRTI should not be considered medically necessary.

Left carpal tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations, Summary.

Decision rationale: The patient is a 64 year old male with signs and symptoms of possible left carpal tunnel syndrome that is supportive of a mild/moderate condition by electrodiagnostic studies. He has failed conservative management of medical management, activity modification, physical therapy and splinting. However, consideration for a steroid injection into the carpal canal had not been documented to help facilitate the diagnosis. The surgeon had stated that 'what his symptoms really are they do not appear to be related to his carpal tunnel syndrome.' This also supports that a steroid injection may be of benefit to facilitate the diagnosis. From page 270, ACOEM, Chapter 11, "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." Further from page 272, Table 11-7, injection of corticosteroids into to the

carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, as the condition appears to be mild to moderate and as recommended from the above guidelines, a consideration for a steroid injection should be documented (or reasoning for not doing so). Thus, left carpal tunnel release should not be considered medically necessary.