

Case Number:	CM15-0135769		
Date Assigned:	07/23/2015	Date of Injury:	01/31/2014
Decision Date:	08/24/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/14/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic 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 injured worker is a 31-year-old male who sustained an industrial injury on 1/31/14. Injury occurred when he was changing the oil on a company truck, reached down and lost his balance. He fell forward inside the engine compartment, lacerating his right hand. He sustained a right palm laceration that was sutured. He was diagnosed with a right palm laceration, crush/contusion of the right hand, and possible radial digital nerve injury. The 3/10/15 treating physician report cited persistent constant moderate right hand pain aggravated by heavy lifting, reaching and pushing activities. Pain was mostly during the day but occasionally at night. Right hand exam documented 1 cm of right forearm atrophy, slight atrophy of the thenar musculature, decreased sensation about the thumb, 4/5 right grip strength weakness, and tenderness about the thenar eminence. The diagnosis was chronic thenar strain with median nerve branch paresthesias. The 4/14/15 right hand MRI impression documented the thenar muscle, including the adductor pollicis brevis muscle were within normal limits, and the flexor tendon of the thumb was intact. There was no evidence of scarring or mass visualized. The 4/15/15 treating physician report documented the injured worker was able to fire the abductor pollicis brevis with good strength, but he had slight decreased sensation. There was 5 mm sensation at the thumb and tip and 3.6 mm at the tip of the thumb, otherwise normal. Carpal tunnel compression test was positive to replicate the symptoms, particularly to the index finger. EMG and nerve conduction study did not show focal signs of compression at the carpal tunnel, but there were some EMG findings on the abductor pollicis brevis. Treatment options were discussed and a diagnostic injection to the carpal tunnel was performed. The injured worker was released to full duty work. The 5/27/15 treating physician report continued numbness and tingling and burning

pain in the 2nd, 3rd, and 4th right hand digits with cramping in the thumb. He reported more numbness and tingling associated with activity. He had undergone an injection but then returned to work so did not get a good sense of improvement. Physical exam documented positive carpal tunnel compression, Phalen's and Tinel's tests, and ability to fire the abductor pollicis brevis. The diagnosis was worsening carpal tunnel syndrome and possible motor nerve laceration, partial laceration of the abductor pollicis brevis. Authorization was requested for right hand open tunnel release/exploration of median nerve, motor branch of thumb and possible nerve repair versus neurolysis of motor branch and post-op occupational therapy 2 times week times 8 weeks to the right hand. The 7/1/15 utilization review non-certified the request for right hand surgery and post-op occupational therapy as there were no formal electrodiagnostic studies submitted for review confirming the diagnosis of right carpal tunnel syndrome and no detailed evidence of conservative treatment failure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right hand open tunnel release/exploration of median nerve, motor brance of thumb and possible nerve repair vs neurolysis of motor brance: Overturned

Claims Administrator 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, Treatment Index, 13th Edition, 2015, Carpal tunnel Syndrome, Carpal Tunnel Release Surgery (CTR).

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: Nerve repair surgery.

Decision rationale: The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. The Official Disability Guidelines recommend nerve reconstructive surgery by repair or graft for lacerated nerves. Guideline criteria have been met. This injured worker presents with persistent right hand pain, numbness and tingling with on-going functional difficulties. Clinical exam findings are consistent with carpal tunnel syndrome and possible motor nerve laceration. There is muscle atrophy, weakness, decreased sensation, and positive provocative testing. There is reported electrodiagnostic evidence of adductor pollicis brevis involvement, but carpal tunnel syndrome is not evidenced. Evidence of long term reasonable and/or comprehensive non-operative treatment and failure has been submitted. Significantly positive clinical findings support the carpal tunnel release in spite of the negative electrical studies. Nerve exploration and possible repair is also supported by the clinical findings and persistent functional loss despite conservative treatment. Therefore, this request is medically necessary.

Associated surgical services: Post-op occupational therapy 2xWk x 8Wks to the right hand:
Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s):
16 and 21.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for carpal tunnel release suggest a general course of 3 to 8 post-operative visits over 3-5 weeks during the 3-month post-surgical treatment period. For median nerve repair, guidelines suggest a general course of 20 visits over 6 weeks during the 6 month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 10 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. This is the initial request for post-operative physical therapy and, although it exceeds recommendations for initial care, is within the recommended general course. Therefore, this request is medically necessary.