

Case Number:	CM15-0181219		
Date Assigned:	09/22/2015	Date of Injury:	07/23/2014
Decision Date:	12/11/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/15/2015

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: 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:

The injured worker is a 44 year old male, who sustained an industrial-work injury on 7-23-14. He reported initial complaints of bilateral hand, wrist, and left thumb pain. The injured worker was diagnosed as having left trigger thumb and bilateral flexor tenosynovitis, and bilateral moderate to severe carpal tunnel syndrome. Treatment to date has included medication, occupational therapy, and brace. Currently, the injured worker complains of persistent bilateral hand and wrist pain with numbness and tingling with inability to extend the left thumb with locking. Medication includes Motrin which helps. Work status us to return to work with restrictions on 9-4-15. Per the primary physician's progress report (PR-2) on 7-24-15, exam notes no tenderness over the bilateral wrist flexor tendons, no pain with resisted active flexion of the wrist and fingers, negative Tinel's sign over the carpal tunnel, Guyon's tunnel, and no change with Phalen's test. There is tenderness over the left A-1 pulley with no obvious locking of the thumb as he is unable to fully bend or extend the IP joint and motor exam is normal. He refused injection for the thumb. The Request for Authorization requested service to include bilateral carpal tunnel release and trigger finger repair and Post-op physical therapy x 12 sessions. The Utilization Review on 9-3-15 modified the request for Bilateral carpal tunnel release and trigger finger repair to Left Trigger Finger (Thumb) Repair and modified Post-op physical therapy x 9 sessions, per CA MTUS (California Medical Treatment Utilization Schedule), ACOEM (American College of Occupational and Environmental Medicine) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Carpal tunnel release surgery (CTR).

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

Decision rationale: The patient is a 44 year old male with a stated diagnosis of bilateral carpal tunnel syndrome. He has undergone conservative management of activity modification, physical therapy, medical management and splinting. Electrodiagnostic studies report findings consistent with a moderate bilateral carpal tunnel syndrome. Previous examinations noted a negative Tinel's and Phalen's at the wrist. There is no evidence of thenar atrophy to suggest a severe condition. "Also of note, the patient does have diabetes and that does make a diagnosis of carpal tunnel more challenging and the individual may require carpal tunnel injections at the discretion of the treating hand surgeon for diagnostic purposes." 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 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. 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. Based on the overall documentation, the patient may have a diagnosis of moderate bilateral carpal tunnel syndrome that is supported by EDS. However, the patient is noted to have a diagnosis of diabetes mellitus, which complicates the clinical scenario. As the patient has a negative Tinel's and Phalen's sign at the wrist, this is not the typical clinical presentation. Therefore, a diagnostic steroid injection may be indicated and as recommended by the above ACOEM guidelines. Therefore, without this injection to facilitate the diagnosis, bilateral carpal tunnel syndrome that would likely benefit from release, the request for Bilateral Carpal Tunnel Release is not medically necessary.

Post-op physical therapy x 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

Decision rationale: As trigger finger was considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines:

Trigger finger (ICD9 727.03): Postsurgical treatment: 9 visits over 8 weeks. *Postsurgical physical medicine treatment period: 4 months. However, based on these guidelines, 12 visits would exceed the therapy guidelines. Therefore, the request for Post Op Physical Therapy is not medically necessary.

Left Trigger Thumb Repair: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care, Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Carpal Tunnel Release Surgery, Indications for Surgery. Adjunctive procedures: The 2008 AAOS CTS Clinical Treatment Guidelines.

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

Decision rationale: The patient is a 44 year old male who was noted to have evidence of a locked left thumb trigger finger. As the patient has failed other conservative management and that the trigger finger is noted to be in a fixed position, a steroid injection should not be considered crucial to treating the clinical condition. A steroid injection had been considered. Therefore, release of a locked trigger thumb should be considered medically necessary despite lack of failure of a steroid injection. From ACOEM, page 271, Chapter 11, 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. Therefore, the request for Left Trigger Thumb Repair is medically necessary.