

Case Number:	CM15-0215621		
Date Assigned:	11/05/2015	Date of Injury:	05/14/2013
Decision Date:	12/18/2015	UR Denial Date:	10/23/2015
Priority:	Standard	Application Received:	11/02/2015

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 45-year-old female who sustained an industrial injury on 5/14/13. Injury occurred when a child threw a trash can and bit her on the right hand between the thumb and index finger, and she fell and rolled on both arms, wrists, and hands. She was diagnosed with a tear of the triangular fibrocartilage complex (TFCC) at its radial attachment and tenosynovitis of the extensor carpi radialis tendons. The 10/7/14 bilateral upper extremity nerve conduction study documented evidence of bilateral moderate carpal tunnel syndrome. She underwent right wrist diagnostic arthroscopy, TFCC debridement, and a post-operative intra-articular pain injection on 10/8/14. The 7/30/15 orthopedic report cited persistent right wrist pain and no benefit from prior surgery. Complaints included pain, weakness, swelling, stiffness, numbness and tingling in the bilateral wrists, hands and fingers. She was not working. Conservative treatment had included pain medications, corticosteroid injection, physical therapy, bracing and activity modification. Right elbow exam documented profuse tenderness to palpation, full range of motion, no swelling or deformity, no evidence of instability and negative cubital tunnel provocative testing. There was diffuse tenderness throughout the forearm to palpation. Right hand and wrist exam documented tenderness to palpation over the ulnar aspect of the wrist, less radially. She had a markedly positive ulnar carpal compression test. There was no instability about the distal radioulnar joint. Tinel's, carpal compression, and Phalen's tests were positive. She was able to make a fist but it was weak. Sensation was decreased in the median nerve distribution. There was no thenar atrophy and finger triggering. Thumb grind and Finkelstein's tests were negative. Grip strength was 0/0/0 pounds right and 15/10/15 left. X-rays of the right wrist were obtained and

showed a 1+ ulnar positive on the right side. The diagnosis included right wrist ulnar carpal impaction syndrome and bilateral carpal tunnel syndrome. The injured worker had evidence of ulnar carpal impaction syndrome, supported by her PA grip radiographs. She had undergone a TFCC debridement. The orthopedist opined that if the ulnar is not shortened at the time of TFCC debridement, persistent symptoms can be the outcome as in this case. A repeat wrist arthroscopy with TFCC debridement and now ulnar shortening osteotomy was recommended with carpal tunnel release at the same time. She had failed conservative treatment for carpal tunnel syndrome and had clear electrodiagnostic evidence. The 9/24/15 orthopedic report cited worsening bilateral wrist pain with numbness on the top of the right hand. She was taking Tramadol and Neurontin for pain and using an H-wave. Clinical exam findings were unchanged. Surgery was pending. Authorization was requested for right wrist arthroscopy, TFCC debridement, ulna shortening, and carpal tunnel release and associated post-operative physical therapy for 12 visits. The 10/23/15 utilization review modified the request for right wrist arthroscopy, TFCC debridement, ulna shortening, and carpal tunnel release to a carpal tunnel release as there was no post-operative imaging to confirm a re-tear of the TFCC. The request for 12 visits of post-op physical therapy was modified to 4 visits consistent with the Post-Surgical Treatment Guidelines for initial post-op treatment for carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right wrist arthroscopy, TFCC (triangular fibrocartilage complex) debridement, ulnar shortening, carpal tunnel release: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand, Triangular fibrocartilage complex (TFCC) reconstruction.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Triangular fibrocartilage complex (TFCC) reconstruction and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 11 Hand, Wrist and Forearm Disorders (Update 2009), page(s) 80-81.

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who fail to respond to conservative management, and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The Official Disability Guidelines recommend TFCC reconstruction as an option. Arthroscopic repair of peripheral tears of the triangular fibrocartilage complex (TFCC) is a satisfactory method of repairing these injuries. Injuries to the triangular fibrocartilage complex are a cause of ulnar-sided wrist pain. The ACOEM updated hand, wrist, and forearm guidelines recommend ulnar shortening procedures for chronic triangular fibrocartilage complex tears for which non-surgical treatment is unsuccessful and there was a demonstrable ulna positive variance. In select cases with ulna positive variance and

without resolution of considerable or incapacitating symptoms or lacking trending towards resolution, this procedure is recommended. 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. Guideline criteria have been met. This injured worker presents with persistent and worsening right wrist/hand pain and numbness. Functional limitations preclude return to work. Clinical exam findings are consistent with radiographic evidence of positive ulnar variance and electrodiagnostic evidence of moderate carpal tunnel syndrome. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary at this time.

12 post-operative physical therapy visits: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

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

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of triangular fibrocartilage complex debridement suggest a general course of 10 post-operative physical medicine visits over 10 weeks, during the 4-month post-surgical treatment period. For carpal tunnel release, guidelines recommend a general course of 3-8 post-operative physical medicine visits over 3-5 weeks, during the 3-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. 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 injured worker has been certified for a carpal tunnel release. There is now a compelling reason submitted to support the medical necessity of care beyond that already certified. The amount of visits is within guidelines for the combined procedures. Therefore, this request is now medically necessary.