

Case Number:	CM15-0031645		
Date Assigned:	02/25/2015	Date of Injury:	05/22/2012
Decision Date:	04/03/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/19/2015

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 patient is a 66 year old female with a reported date of injury on 5/22/12 who requested authorization for left carpal tunnel release and left 1st CMC arthroplasty. She had previously undergone left carpal tunnel release in 2004. She is noted to complain of numbness, tingling and weakness of the left hand, as well as left wrist pain. Previous examinations noted positive Phalens's, positive Tinel's, a well-healed left carpal tunnel scar, positive 1st CMC tenderness and positive Finkelstein's test. Previous radiographs are stated to show severe CMC arthritis. Previous electrodiagnostic studies are stated to show moderate-to-severe left carpal tunnel syndrome. Request was made to re-release the left carpal tunnel and 1st CMC interpositional arthroplasty. It was stated that this was authorized by previous AME dated 9/9/13. Medical management of the pain has included topical creams and Tramadol. The patient had been instructed not to take NSAIDs due to her history of HTN and DM. Documentation from 12/23/14 notes that the requesting/treating physician will provide copies of the actual electrodiagnostic studies and actual radiographic reports. Actual electrodiagnostic study reports and radiographic reports were not provided for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left carpal tunnel release, endoscopic vs open: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient is a 66 year old female with signs and symptoms of possible left carpal tunnel syndrome. However, there has been insufficient medical documentation of conservative management including bracing. The actual electrodiagnostic study report was not included in the documentation, as well. This report is stated to show moderate to severe left carpal tunnel syndrome. The patient is not documented to have clinical signs of a severe compromise, which could include thenar atrophy. Severe findings may obviate the need for attempted conservative management. Therefore, left carpal tunnel release should not be considered medically necessary. From page 270, ACOEM, Chapter 11 CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. From Table 11-7, Splinting is first-line treatment of carpal tunnel syndrome. A steroid injection is recommended after failure of splinting and medications in mild or moderate cases of carpal tunnel syndrome.

Left 1st CMC arthroplasty, endo vs open: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Cook, Geoffrey S. M.D.; Lalonde, Donald H. M.D., MOC-PS(SM) CME Article: Management of Thumb Carpometacarpal Joint Arthritis, Plastic & Reconstructive Surgery: January 2008 - Volume 121 - Issue 1S - pp 1-9.

Decision rationale: The patient is a 66 year old female with documented left 1st CMC tenderness and stated radiographs of severe CMC arthritis. There has not been adequate documentation of sufficient conservative management including splinting. Detailed explanation of the severe CMC arthritis was not provided, as well as an actual report of the radiographic study. Thus, without clear evidence of the clinical problem and sufficient conservative management, CMC interpositional arthroplasty should not be considered medically necessary. From ACOEM, page 270 on general surgical indications: Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature, Fail to respond to conservative management, including worksite modifications. Have clear clinical and special study evidence of a lesion that has been shown to benefit. As documented in the above article from Cook et al, Not all patients with arthritis of the thumb carpometacarpal joint will require surgery. There are some patients with visible deformities and marked radiographic changes who are symptom free and require no treatment. The first step in relieving a symptomatic patient is adequate patient education regarding the cause of the pain and behavior modification to minimize pain production. Nonsteroidal anti-inflammatory medication can be added should the

pain persist. If this is not enough to alleviate the symptoms, a custom-made short opponens splint can be fabricated to stabilize the carpometacarpal joint while still allowing the interphalangeal and/or the metacarpophalangeal joint to move. Finally, should splinting and nonsteroidal anti-inflammatory drugs prove ineffective in eliminating the pain, a steroid can be injected into the carpometacarpal joint. Thus, the clinical problem has not been adequately defined and there has been insufficient documentation of conservative management. Thus, CMC interpositional arthroplasty should not be considered medically necessary.