

<b>Case Number:</b>	CM15-0044829		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	12/05/1980
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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:

The injured worker is a 54-year-old female who sustained an industrial injury on 12/05/80, relative to her job duties. The 2/13/14 bilateral upper extremity EMG/NCV study evidenced severe bilateral carpal tunnel syndrome. Records indicated that the injured worker sustained an insect bite at work on 8/24/14 to her right foot with immediate swelling. On 9/2/14, she presented with swelling, bruising, discoloration, and significant pain. Symptoms persisted despite antibiotic therapy and she developed a black spot on her foot. Additional antibiotics were prescribed and imaging was performed. She was diagnosed with cellulitis on 11/12/14. The 1/26/15 treating physician report cited complaints of bilateral hand numbness and tingling with triggering in the bilateral thumbs, ring, and small fingers. Objective findings documented bilateral wrist atrophy with pain at the thenar pads and positive Tinel's and Phalen's tests. The injured worker had received a trigger finger injection from a prior physician and had finished a physical therapy program with decreased triggering of the fingers. She was being followed by another physician for an insect bite to right dorsal foot with cellulitis. Authorization was requested for bilateral carpal tunnel release and bilateral thumb/ring/small finger trigger release with possible tenosynovectomy/tenolysis, initial post-operative therapy two times a week for four weeks and continuous cold therapy unit (purchase). The 2/18/15 utilization review certified a request for bilateral carpal tunnel release with possible flexor tenosynovectomy and/or median neurolysis and pre-operative medical clearance. The request for bilateral thumb, ring and small finger trigger release surgery with possible tenosynovectomy/tenolysis was non-certified as there was no current clinical exam documented of triggering and the patient was under active

treatment for an infection. The request for 8 initial post-op therapy sessions was modified to 4 initial visits consistent with Post-Surgical Treatment Guidelines. The request for purchase of a cold therapy unit was modified to a 7-day rental of a cold therapy unit consistent with guidelines. The 3/9/15 treating physician report cited bilateral wrist/hand pain with associated numbness and tingling and triggering, locking, and snapping with activity. Physical exam documented pain and atrophy over the bilateral thenar eminences, increased tenderness over the flexor/extensor tendons and A-1 pulleys of the bilateral thumbs, ring and small fingers with active triggering. The treatment plan indicated that the injured worker would not proceed with carpal tunnel releases until trigger finger releases are authorized. Continued follow-up was noted with another physician for the right foot cellulitis.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral Thumb/Ring/Small trigger finger release with Possible Tenosynovectomy/ Tenolysis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Forearm, wrist & hand (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Tenolysis; Tenosynovectomy.

**Decision rationale:** The California MTUS guidelines relative to trigger finger surgery state that one to 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 surgical procedure may be necessary to permanently correct persistent triggering. The MTUS guidelines do not provide specific indications for tenosynovectomy/tenolysis. The Official Disability Guidelines criteria for flexor tenolysis include patient willingness to commit to a rigorous course of physical therapy as vigorous postoperative ROM is required, and have good strength in flexor and extensor muscles of the hand with intact nerves to flexor muscles. Tenolysis is contraindicated in patients with active infection, motor-tendon problems secondary to denervation, and unstable underlying fractures requiring fixation and immobilization. Guideline criteria have not been fully met. This patient presents with persistent bilateral thumb, ring and little finger triggering, snapping, and locking with activity, and despite injection and physical therapy. The request for trigger finger release would therefore typically be supported. However, the additional request for possible tenosynovectomy/tenolysis is not supported in the presence of her active right foot cellulitis. Therefore, this request overall is not medically necessary at this time.

**8 initial post-op therapy sessions: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15-16, 20.

**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. An initial course of therapy would be supported for one-half the general course or 4 visits. Guidelines for trigger finger release would support a general course of 9 visits over 8 weeks, with 4 or 5 initial visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 2/8/15 utilization review recommended partial certification of 4 post-operative physical therapy visits consistent with guidelines for the certified carpal tunnel release. There is no compelling reason submitted to support the medical necessity of additional care. Therefore, this request is not medically necessary.

**Associated surgical service: 1 Continuous cold therapy unit purchase:** 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) - Carpal tunnel Syndrome (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel syndrome: Continuous cold therapy (CCT).

**Decision rationale:** The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous cold therapy is an option for up to 7 days in the post-operative setting following carpal tunnel release. Patients who used continuous cold therapy showed significantly greater reduction in pain, edema (wrist circumference), and narcotic use post-op than did those using ice therapy. The 2/8/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.