

Case Number:	CM15-0239661		
Date Assigned:	12/16/2015	Date of Injury:	01/18/2014
Decision Date:	01/28/2016	UR Denial Date:	11/20/2015
Priority:	Standard	Application Received:	12/08/2015

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 female with an industrial injury dated 01-18-2014. A review of the medical records indicates that the injured worker is undergoing treatment for right carpal tunnel syndrome. According to the primary treating physician medical re-evaluation dated 06-24-2015, the injured worker presented as part of ongoing care and treatment. Documentation noted that the injured worker has still not heard anything regarding her right middle finger trigger release surgery that has been recommended. The injured worker reported improvement with right shoulder. The injured worker still complains of aches and pains on the right side. Objective findings (06-24-2015) for right wrist and hand revealed tenderness to palpitation of the anatomical snuffbox and carpal bones, full range of motion, decrease flexion of fingers, and active triggering of the right middle finger with palpable tender flexor tendon nodule at the A1 pulley. Positive Phalen's and Finkelstein's maneuver were also noted on exam. MRI of the right wrist report dated 03-17-2014 revealed subchondral cyst formation with the scaphoid and lunate, otherwise unremarkable. According to the neurophysiological evaluation dated 11-05-2015, the injured worker reported pain in the second through fourth digits of the right hand extending to the right arm and to neck. The injured worker had numbness and tingling in the second through fourth digits of the right hand extending to the right elbow and locking of the third digit of the right hand. The symptoms are increased with activity. Pain level increase to a 7 out of 10 on a visual analog scale (VAS). Objective findings (11-05-2015) revealed diminished sharp sensation at the volar aspect of the first through fourth digits of the right hand. The treating physician reported "slowing of the median sensory and motor nerve conduction across the right wrist and

mild to moderate median demyelinating entrapment neuropathy at the carpal tunnel." Treatment has included electrodiagnostic studies, MRI of the right wrist on 03-17-2014, prescribed medications, urine drug screen, functional capacity evaluation and periodic follow up visits. The treatment plan included right carpal tunnel release and middle finger trigger release. The utilization review dated 11-20-2015, non-certified the request for right carpal tunnel release and middle finger trigger release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Carpal Tunnel Release: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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 female with signs and symptoms of a right carpal tunnel syndrome. Conservative management has included NSAIDs, physical therapy and splinting for over one year. The diagnosis is supported by electrodiagnostic studies, which document a mild to moderate condition. The requesting surgeon documented that he would not advise a steroid injection, due to the possibility of median nerve injury. From ACOEM, Chapter 11, page 270, "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 post surgery 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." 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. From page 265, "Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived." In this case, the patient clearly has evidence of a right carpal tunnel syndrome and should not need a steroid injection to facilitate the diagnosis. She has been documented to have undergone recommended conservative management for over a year that included physical therapy as well. Thus, right carpal tunnel release should be considered medically necessary. The UR stated that conservative management had not been documented, including a steroid injection. As reasoned above, conservative management was documented and a steroid injection in this case should not be necessary.

Middle Finger Trigger Release: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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 female with a right trigger finger. There has not been documentation of a steroid injection, as recommended by ACOEM. From 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, right trigger finger release should not be considered medically necessary.