

Case Number:	CM14-0127714		
Date Assigned:	09/23/2014	Date of Injury:	04/01/2013
Decision Date:	10/22/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/12/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 78 year old female with a 4/1/13 injury date. The mechanism of injury was not provided. In a 2/20/14 report, the patient complains of bilateral hand pain which radiates to the elbows, and numbness and tingling in the hands at night and with repetitive activities. The pain is relieved by using medication, hand braces, exercises, and resting. Objective findings include diffuse and moderate tenderness over both wrists and hands. The office notes are handwritten and portions are illegible. In a 5/9/14 office note, objective findings include positive Durken's compression and reverse compression tests of the wrists. In a 6/20/14 office note, the patient complains of right wrist numbness and tingling. Objective findings include positive Tinel's, decreased range of motion with pain, and A1 pulley right index/middle fingers with triggering. In a portion of an 8/4/14 office note that is difficult to read, the provider appears to indicate that 2/20/14 electrodiagnostic tests were positive for carpal tunnel syndrome, and that they are proceeding with a standard right wrist carpal tunnel injection as authorized. A 2/20/14 EMG/NCV of the upper extremities was normal. Diagnostic impression: carpal tunnel syndrome. Treatment to date: medications, braces, exercises, rest. A UR decision on 7/24/14 partially certified the request for ultrasound guided right wrist CT injection, right index, and middle trigger injection, to allow for standard right wrist injection only. The rationale was that there was no documentation indicating the patient had trigger fingers, and the guidelines do not support the use of ultrasound guidance with wrist injections. The request for bilateral wrist splints was denied on the basis that there was prior notation that the patient has used wrist braces in the past, and there is no discussion that indicates why the patient needs additional wrist splints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound-guided right wrist CT injection, right index, middle trigger injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Carpal Tunnel Syndrome Chapter, Forearm, Wrist, and Hand Chapter. Other Medical Treatment Guideline or Medical Evidence.

Decision rationale: CA MTUS states that in cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The primary treating physician may refer for a local Lidocaine injection with or without corticosteroids. In addition, ODG states that corticosteroid injections will likely produce significant short-term benefit, but many patients will experience a recurrence of symptoms within several months after injection. CA MTUS states that 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. In the present case, the documentation is difficult to read. Given that the EMG/NCV was negative for carpal tunnel syndrome, to certify the request there would need to be clear, legible physical exam findings that show positive objective signs of carpal tunnel syndrome such as positive Tinel's at the median nerve, positive Phalen's, positive Durken's compression test, plus/minus atrophy, plus/minus strength (especially of thumb abduction), and any sensory disturbances with 2 pt discrimination. There are also instances where it is unclear whether the right or left wrist is being discussed. The guidelines are silent with respect to the use of ultrasound in carpal tunnel injections, but an article by Ustun N et al did validate its efficacy. However, the larger issue is the negative EMG/NCV in conjunction with poorly documented and inconsistent exam findings. On this basis, the request as a whole cannot be certified, even though trigger finger injections are generally recommended by the guidelines, and the available documentation has a brief mention of triggering in the right index and middle fingers. Therefore, the request for Ultrasound-guided right wrist CT injection, right index, middle trigger injection, is not medically necessary.

Bilateral wrist splints (dispensed): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): SUMMARY TABLE 2. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Carpal Tunnel Syndrome Chapter.

Decision rationale: CA MTUS guidelines recommend wrist splinting for acute, subacute, or chronic CTS; moderate or severe acute or subacute wrist sprains; acute, subacute, or chronic ulnar nerve compression at the wrist; acute, subacute, or chronic radial nerve neuropathy;

scaphoid tubercle fractures; or acute flares or chronic hand osteoarthritis; Colles' fracture. In the present case, there is documentation that the patient has already tried "wrist bracing" as part of conservative treatment. There is no rationale or discussion that explains why additional wrist splints are needed. Therefore, the request for bilateral wrist splints (dispensed) is not medically necessary.