Case Number:	CM14-0174172		
Date Assigned:	10/27/2014	**Date of Injury:**	05/20/2014
Decision Date:	12/03/2014	**UR Denial Date:**	09/26/2014
Priority:	Standard	**Application Received:**	10/21/2014

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 Orthopedic Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Texas. 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:

The injured worker is a 55-year-old female who reported injuries due to cumulative and repetitive movement on 05/20/2014. On 08/15/2014, her diagnoses included bilateral carpal tunnel syndrome, mild to moderate in degree. On 09/09/2014, her diagnoses were noted to include bilateral carpal tunnel syndrome, left greater than right, right elbow lateral epicondylitis (tennis elbow syndrome), probable ganglion cyst volar radial right wrist, and flexor tendovaginitis, left middle finger (trigger digit). A neurological exam on 08/15/2014 included nerve conduction studies to confirm the diagnosis of carpal tunnel syndrome. Her medications included ibuprofen 800 mg as needed. Upon examination, there was tenderness noted at the lateral epicondyle, the right volar wrist, and the flexor sheath of the left middle finger. Provocative testing revealed positive lateral epicondylitis (resisted middle finger extension), and trigger digit positive left middle finger. X-rays of the wrist and hand revealed no fracture, dislocation, subluxation, arthritis, or other abnormality. She was given the option of cortisone injections into her carpal tunnels and flexor sheath of the left middle finger; however, she declined. She wished a more aggressive management. This led to the ultimate request for carpal tunnel release and left middle trigger digit release. It was recommended that she wear bilateral neutral wrist splints loosely, primarily at night. Formal therapy was not prescribed. Beginning on 05/28/2014, this injured worker participated in an unknown number of physical therapy sessions. The results of those sessions were not available for review. There was no Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open versus endoscopic left carpal tunnel release.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (updated 02/20/2014)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The request for open versus endoscopic left carpal tunnel release is medically necessary. The California ACOEM Guidelines note that surgical decompression of the median nerve usually relieves carpal tunnel syndrome symptoms. High quality scientific evidence shows success in the majority of patients with an electro-diagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest 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. With proper training and equipment, endoscopic carpal tunnel release can be done safely, with complication rates comparable to those for the open technique and with high patient satisfaction. The Official Disability Guidelines recommend carpal tunnel release after an accurate diagnosis of moderate or severe carpal tunnel syndrome. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. Carpal tunnel release is well supported both open and endoscopic. Carpal tunnel syndrome may be treated initially with education, activity modification, medications, and night splints before injection is considered, except in the case of severe CTS. The indications for surgery, for not severe CTS requires all of the following: symptoms including pain/numbness/paresthesia/impaired dexterity requiring 2 of the following: abnormal CAT scan diagram scores, nocturnal symptoms, flick sign (shaking hand); findings by physical exam requiring 2 of the following, including: compression test, Semmes-Weinstein monofilament test, Phalen's sign, or Tinel's sign, decreased 2 point discrimination, and mild thenar weakness (thumb abduction). There must be no current pregnancy, and there must be initial conservative treatment requiring 3 of the following, including : activity modification equal or greater than 1 month; night wrist splint equal or greater than 1 month; nonprescription analgesia, for example: acetaminophen, home exercise training provided by the physician, healthcare provider, or therapist; and positive electrodiagnostic testing. Other than declining the corticosteroid injection, which was optional, it appears that this injured worker has met the criteria for the evidence based guidelines for carpal tunnel release surgery. The guidelines indicate that endoscopic has better patient satisfaction outcomes than open surgery. Therefore, the recommendation will be for the endoscopic left carpal tunnel release as medically necessary.

Left middle finger trigger release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand updated 08/08/14.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand, Percutaneous Release (of the Trigger Finger and/or Trigger Thumb).

Decision rationale: The request for left middle trigger finger release is not medically necessary. The California/ACOEM Guidelines recommend 1 or 2 injections of Lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger, which are almost always sufficient to clear the symptoms of trigger finger and restore function. The Official Disability Guidelines recommend trigger finger release in cases where symptoms persist after steroid injection. This injured worker was given the option of a cortisone injection into the flexor sheath of her left middle finger; however, she declined. The guidelines clearly note that corticosteroid injections are the preferred treatment of choice. Therefore, this request for left middle finger trigger release is not medically necessary.

Associated surgical service: pre-op labs: electrocardiogram (EKG), CBC, CMP, prothrombin time (PT): 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), Low Back updated 08/22/14

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Preoperative Lab Testing.

Decision rationale: The request for associated surgical service: pre-op labs: electrocardiogram (EKG), CBC, CMP, prothrombin time (PT) is not medically necessary. The Official Disability Guidelines note that preoperative tests are excessively ordered, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. This injured worker does not fall into any of the above categories. The need for pre-op testing was not clearly demonstrated in the submitted documents. Therefore, this request for associated surgical service: pre-op labs: electrocardiogram (EKG), CBC, CMP, prothrombin time (PT) is not medically necessary.

Associated surgical service: initial post-op physical therapy, 3 times a week for 4 weeks, bilateral wrist/hand: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16 , 22.

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

Decision rationale: The request for associated surgical service: initial post-op physical therapy, 3 times a week for 4 weeks, bilateral wrist/hand is not medically necessary. The California MTUS Guidelines note that there is limited evidence demonstrating the effectiveness of physical therapy or occupational therapy for carpal tunnel syndrome. The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to a maximum of 8 visits. Carpal tunnel release surgery is a relatively simple operation that should not require extended multiple therapy office visits for recovery. The guidelines note that the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery performed. The recommendation for endoscopic carpal tunnel release is 3 to 8 visits over 3 to 5 weeks. Half of that would be a maximum of 4 visits. The requested number of therapy visits exceeds the recommendations in the guidelines. Additionally, the surgery was going to be performed on only one hand, so there was no need for therapy on both wrists and hands. Therefore, this request for associated surgical service, initial post-op physical therapy 3 times a week for 4 weeks, bilateral wrist/hand, is not medically necessary.