

Case Number:	CM15-0011907		
Date Assigned:	01/29/2015	Date of Injury:	05/24/2001
Decision Date:	03/18/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	01/21/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 60 year old female, who sustained an industrial injury on 5/24/2001. The injured worker had complaints in her bilateral wrists and hands, right being greater than left. The pain is documented as being constant sharp, aching and cramping with constant shooting, stabbing, throbbing, tingling, electrical, muscle tightness and muscle spasms. The pain radiates to the left upper arm, left forearm, left hand, left fingers, right upper arm, right forearm, right hand and right fingers and having increased numbness. The documentation noted on 9/2/14 had an injection to the right carpal tunnel with sustained benefits. The diagnoses have included carpal tunnel syndrome, opioids type dependence continuous. According to the utilization review performed on 1/13/15, the requested Bilateral Transverse Carpal Ligament Injections has been non-certified. The CA MTUS Chronic Pain Medical Treatment Guidelines does not address and CA MTUS Forearm, wrist and hand complaints (ACOEM practice guidelines, 2nd edition (2004) Chapter 11) was used. The utilization review noted that there was no documentation of conservative treatment of non-steroidal anti-inflammatory medications, physical therapy, activity modification, or use of a wrist splint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Transverse Carpal Ligament Injections: Overturned

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): 265.

Decision rationale: The ACOEM section on wrist complaints states: Most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. The exception is corticosteroid injection about the tendon sheaths or, possibly, the carpal tunnel in cases resistant to conservative therapy for eight to twelve weeks. For optimal care, a clinician may always try conservative methods before considering an injection. DeQuervains tendinitis, if not severe, may be treated with a wrist-and-thumb splint and acetaminophen, then NSAIDs, if tolerated, for four weeks before a corticosteroid injection is considered. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. 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. Trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after two injections by the primary care or occupational medicine provider (see Table 11-4). The patient has the diagnosis of carpal tunnel syndrome for greater than 12 weeks and has failed conservative therapy. Therefore per the guidelines cited above injection into the carpal tunnel is an accepted therapy option. Therefore the request is certified.