

<b>Case Number:</b>	CM15-0113109		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	07/21/2014
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand 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 55-year-old male who sustained an industrial injury on 7/21/14. The injured worker was diagnosed as having closed fracture of carpal bone unspecified, fracture of unspecified part of radius with ulna - closed and pain in joint involving lower leg. Currently, the injured worker was with complaints of left upper extremity pain. Previous treatments included occupational therapy, medication management and a protective brace. Previous diagnostic studies included a left knee magnetic resonance imaging (10/28/14) revealing a small vertical tear in the superior leaflet of the periphery of the posterior horn of the medial meniscus, left patellar tendinosis and small left knee joint effusion. The plan of care was for surgical intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Redo Carpal Tunnel Release, Median Nerve Block, Flexor Synovectomy, Median Internal Neurolysis, Hypothenar Fat Flap: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 38, 271.

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

**Decision rationale:** The carpal tunnel release is medically necessary. According to the ACOEM Practice Guidelines, 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. This patient has significant symptoms of carpal tunnel syndrome, an exam consistent with carpal tunnel syndrome and positive electrodiagnostic studies for median nerve compression. Because the patient has worsening numbness, adjunctive procedures including synovectomy, neurolysis and fat flap may be necessary depending on the operative findings. Clinical exam shows synovitis, and synovectomy is likely to be required. Therefore, the request is medically necessary.

**Left Ring A1 Release and Cyst Excision:** Overturned

**Claims Administrator 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.

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

**Decision rationale:** According to the ACOEM Practice Guidelines, 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 this case, the patient has a cyst on top of the tendon sheath that is painful. While steroid injection is normally required prior to trigger release, surgery is appropriate to remove the cyst from the pulley, and the pulley can be released at the same time. Therefore, the request is medically necessary.

**Left Radial Neurolysis/Neuroplasty:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271.

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

**Decision rationale:** According to the ACOEM Practice Guidelines, referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature; Fail to respond to conservative management, including worksite modifications; Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long

term, from surgical intervention. The patient has a positive nerve conduction test for radial nerve compression, and is symptomatic with pain and radial sided numbness. ACOEM supports hand surgery treatment given the special study evidence (nerve conduction testing) of a lesion of the radial nerve. Therefore, the request is medically necessary.

**Outpatient Facility:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Surgery of this magnitude needs to be performed in a surgery center or hospital. It cannot be performed in an office setting. An outpatient facility is required. Therefore, the request is medically necessary.

**Associated Surgical Services: Cold Therapy/Compression Unit:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 Chapter.

**Decision rationale:** According to the Official Disability Guidelines, continuous cold therapy is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than 7 days, including home use. The patient will be undergoing repeat carpal tunnel release with synovectomy. Therefore, the request is medically necessary.