

<b>Case Number:</b>	CM15-0068229		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	05/13/2014
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic 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 42-year-old female who sustained an industrial injury on 5/13/14. Injury occurred when she was pulling a handle on a tote bag and heard a pop in her right wrist and was unable to move her hand. Conservative treatment included physical therapy, wrist support, TENS unit, activity modification, oral steroids, and anti-inflammatory medication. The 7/28/14 right wrist MRI impression documented partial tear of the membranous portion of the scapholunate interosseous ligament without widening of the corresponding interosseous space. There was no communicating defect. There was a longitudinal split tear of the extensor carpi ulnaris tendon over a length of 2 cm centered over the ulnar styloid. The 9/5/14 electrodiagnostic study findings revealed mild right carpal tunnel syndrome. The 1/22/15 progress report cited radial wrist pain localized to the second dorsal compartment. Pain was reproduced by direct pressure and opposed wrist extension. She had continued symptoms in the carpal tunnel area with positive Tinel's, Phalen's, and compression test. Grip strength was 0/2/0 on the right and 24/22/24 on the left. The diagnosis was right carpal tunnel syndrome, second dorsal compartment tendinitis, and MRI evidence of tendinitis of the sixth dorsal compartment presently asymptomatic. She had failed almost 7 months of conservative treatment with specific pathology involving the median nerve at the carpal tunnel. The treatment plan recommended right open carpal tunnel release simultaneously with a second dorsal compartment corticosteroid and local anesthetic injection. Additional requests included 12 visits of post-operative therapy starting the third post-op week, and splinting for the first 2 to 3 weeks. The patient was temporarily totally disabled as there was no light duty work available. The 3/5/15 treating physician report indicated that he had requested

authorization for surgery with no response. He documented that the injured worker was very bothered by the paresthetic sensation and numbness and was unable to sleep at night. Grip strength was 0/2/2 right and 22/20/20 left. She was off work and awaiting authorization for surgery. The 3/19/15 utilization review non-certified the request for right open carpal tunnel release and associated requests as there was a lack of documentation regarding failed conservative treatment or evidence of nocturnal symptoms. The 4/6/15 response from the treating physician indicated that the injured worker had neurologic symptoms consistent with electrodiagnostic evidence for carpal tunnel syndrome. The injured worker had declined a corticosteroid injection for the carpal tunnel. Phalen's and Tinel's tests were positive. She had been off work and thus had activity modification, had been using a wrist splint for months, and was taking Meloxicam, omeprazole, and tramadol. An injection to the 2nd dorsal compartment for findings of tendinitis with splinting to rest the structure is reasonable initial treatment. Authorization of these requests were again requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right Open Carpal Tunnel Release: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th edition (web), 2014, carpal Tunnel, Indication for Surgery- Carpal Tunnel Release.

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

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. Guideline criteria have been met. This injured worker presents with persistent numbness and paresthesia with nocturnal symptoms. Functional limitations preclude return to work. Clinical exam findings are consistent with electrodiagnostic evidence of carpal tunnel syndrome. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

#### **Right 2nd D/C Injection of Corticosteroid and Local Anesthetic: 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): 272.

**Decision rationale:** The California MTUS guidelines recommend initial corticosteroid injections for moderate cases of tendonitis as an option. Guideline criteria have been met. The use of a corticosteroid injection for the documented second dorsal compartment tendonitis is reasonable and consistent with guidelines. Therefore, this request is medically necessary.

**Post-operative Physical Therapy 3 x 4:** Upheld

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

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

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for carpal tunnel release suggest a general course of 3 to 8 post-operative visits over 3-5 weeks during the 3-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Although post-operative therapy would be supported following carpal tunnel release, this request for 12 post-operative physical therapy visits exceeds guideline recommendations for the initial and general course of treatment. There is no compelling reason presented to support an exception to guidelines. Therefore, this request is not medically necessary.

**Post-operative Splint:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel- Splint.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

**Decision rationale:** The California MTUS guidelines support splinting as a first line conservative treatment for carpal tunnel syndrome and tendinitis, and for post-operative treatment. Guideline criteria have been met. This request for post-operative splinting for 2 to 3 weeks following carpal tunnel release and the second dorsal compartment tendon injection is consistent with guidelines. Therefore, this request is medically necessary.