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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/24/2013

7/27/2012

8/5/2013

CM13-0007356

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right redo carpal tunnel release is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **median nerve block is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Synovectomy is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **possible medial internal neuralysis is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **possible hypothenar fat flap is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **post-operative physical therapy three times a week for two weeks for the right wrist is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **splint post-operative is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right redo carpal tunnel release is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **median nerve block is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Synovectomy is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **possible medial internal neuralysis is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **possible hypothenar fat flap is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **post-operative physical therapy three times a week for two weeks for the right wrist is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **splint post-operative is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 treatments and/or services at issue.

### Expert Reviewer Case Summary:

The patient is a 51-year-old male who reported a work related injury on 07/27/2012. The patient underwent subsequent right carpal tunnel release, flexor tenosynovectomy, right ulnar nerve decompression at the elbow, and anterior subcutaneous transposition of the ulnar nerve as of 10/24/2012. The patient underwent a subsequent extensive postoperative course of physical therapy interventions. The patient presented on 05/22/2013 under the care of Dr. [REDACTED]. The provider documented the patient reports his pattern of symptoms was slowly improving, and describes the pain as chronic, mild, moderate, intermittent, sharp, and aching. The provider documented, upon physical exam of the patient, full range of motion of the bilateral wrists was noted

with pain elicited. Testing revealed that Finkelstein's, Phalen's, and Tinel's were negative bilaterally, and the patient's hand grip was decreased bilaterally. The patient had tenderness over the volar carpal area bilaterally. 06/17/2013 clinical note reports the patient was seen under the care of Dr. [REDACTED]. The provider documents the patient now states that the numbness and tingling have been worsening gradually on the right median and ulnar nerve distribution. The provider documented the patient had complete intact flexors, extensors, and intrinsic function, and the patient can make a tight fist and fully extend the fingers. The patient denies pain over the right cubital tunnel with negative elbow flexion testing. The patient had moderate pain over the right carpal tunnel incision, especially at the proximal margin. The patient had a positive Tinel's and Phalen's sign over the right carpal tunnel. The patient complains of severe pain over the right anterior shoulder, radial abduction, and external rotation. Elicitation of significant pain and discomfort were reported. The provider documented the patient would be referred due to recurrent right carpal and cubital tunnel syndrome for repeat nerve conduction study. Electrodiagnostic studies of the patient's bilateral upper extremities performed by Dr. [REDACTED] dated 07/09/2013 revealed normal EMG of the bilateral upper extremities; however, nerve conduction studies revealed a severe residual right carpal tunnel syndrome and a slight residual left carpal tunnel syndrome, evidencing either a recurrence of the patient's carpal tunnel syndrome or an incomplete release. The clinical note dated 07/15/2013 reports the patient was seen for followup under the care of Dr. [REDACTED]. The provider documented a review of the patient's nerve conduction studies that were consistent with bilateral carpal tunnel syndrome, right worse than left, and consistent with physical symptoms. The provider documented the patient had slight swelling over the right volar distal forearm with worsening carpal tunnel syndrome indicative of flexor tenosynovial proliferation. There was no obvious evidence of thenar or first dorsal interosseous muscle atrophy, and the patient had a positive Tinel's and Phalen's sign over the bilateral carpal tunnel, but none over the Guyon's canal. Phalen's and Durkan's maneuvers elicit severe burning pain radiating up along the volar forearm and upper lateral arm areas. Despite the use of protective brace and anti-inflammatory medications, the patient's right carpal tunnel symptoms have gradually worsened, per the provider. The provider documented the patient opted for surgical interventions as the patient had failed prolonged conservative treatment, including protective bracing, anti-inflammatory medications, therapy, and corticosteroid injections. The provider recommended the patient undergo a right carpal tunnel release with possible flexor synovectomy, median nerve internal neurolysis, and hypothenar fat flap if indicated.

#### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

## 1) Regarding the request for right redo carpal tunnel release:

### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition (2004), pg. 265, 270, which is a part of the MTUS. And the Official Disability Guidelines (ODG), Treatment Index, 11<sup>th</sup> Edition-Carpal Tunnel Syndrome, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 270, Carpel Tunnel Syndrome, which is a part of the MTUS.

### Rationale for the Decision:

After a review of the records provided, the employee underwent a right carpal tunnel release in 10/2012, and completed a significant postoperative course of physical therapy interventions. However, recurrence of symptoms began to appear upon physical exam of the employee between 05/2013 and 06/2013. The employee was recommended to undergo repeat electrodiagnostic studies of the bilateral upper extremities, which did, in fact, evidence a severe radial carpal tunnel syndrome to the right. The employee has attempted lower levels of conservative treatment to include a lengthy course of postoperative physical therapy interventions, injection therapy, and anti-inflammatories without resolve of his symptoms, as evidenced by positive Tinel's, positive Phalen's, and decreased grip strength. ACOEM indicates, "Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint." Given all of the above, **the request for Synovectomy is medically necessary and appropriate.**

## 2) Regarding the request for median nerve block:

### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 270, Carpel Tunnel syndromw, which is a part of the MTUS.

### Rationale for the Decision:

A review of the records indicates the median nerve block is supported as the employee is a surgical candidate for a right carpal tunnel release redo. **The request for median nerve block is medically necessary and appropriate.**

**3) Regarding the request for Synovectomy:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the The Official Disability Guidelines (ODG)-Adjunctive procedures, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Carpal Tunnel-Adjunctive Procedures, which is not a part of the MTUS.

Rationale for the Decision:

A review of the records indicates the Synovectomy is medically necessary for the employee as the provider documented the employee presents with worsening carpal tunnel syndrome indicative of a flexor tenosynovial proliferation. **The request for Synovectomy is medically necessary and appropriate.**

**4) Regarding the request for possible medial internal neuralysis:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the The Official Disability Guidelines (ODG)-Adjunctive procedures, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines-Adjunctive procedures, which is not a part of the MTUS.

Rationale for the Decision:

After a review of the records provided, the employee presents status post a previous right carpal tunnel release, with evidence of a severe recurrence of carpal tunnel syndrome, the current request is supported. **The request for possible medial internal neuralysis is medically necessary and appropriate.**

**5) Regarding the request for possible hypothenar fat flap:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the The Official Disability Guidelines (ODG)-Adjunctive procedures, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer

based his/her decision on the Official Disability Guidelines-Adjunctive procedures, which is not a part of the MTUS.

Rationale for the Decision:

After a review of the records provided, the employee presents status post a previous right carpal tunnel release, with evidence of a severe recurrence of carpal tunnel syndrome, the current request is supported. **The request for possible hypothenar fat flap is medically necessary and appropriate.**

**6) Regarding the request for post-operative physical therapy three times a week for two weeks for the right wrist:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on the Post-Surgical Treatment Guidelines, Clean Copy, page 15-16, which is a part of the MTUS.

Rationale for the Decision:

California MTUS Clean Copy Postsurgical Guidelines indicate, "Initial course of therapy means 1/2 of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision D-1 of this section." Guidelines would support 4 sessions of physical therapy postoperatively for this employee. After a review of the records provided, the current request is excessive in nature and exceeds guidelines. **The request for post-operative physical therapy three times a week for two weeks for the right wrist is not medically necessary and appropriate.**

**7) Regarding the request for splint post-operative:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 264, Carpal Tunnel Syndrome, which is part of the MTUS.

Rationale for the Decision:

After a review of the records provided, the current request for splinting is not supported. The employee has had 2 previous carpal tunnel releases, 1 to the left and 1 to the right. It is assumed that the employee utilized splint postoperatively. Additionally, the provider documents the employee has been utilizing a splint throughout the course of treatment. Therefore, the employee does have his DME available to him. California MTUS/ACOEM indicates, "Initial treatment of carpal tunnel syndrome should include night splinting." **The request for splint post-operative is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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