

Case Number:	CM13-0008084		
Date Assigned:	01/10/2014	Date of Injury:	05/01/2000
Decision Date:	03/19/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Plastic and Reconstructive Surgery, and is licensed to practice in Maryland. 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 physician 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 patient is a 45 year old female who sustained a work-related injury on 5/1/00. She suffered repetitive injury to her low back, bilateral upper extremities, neck, and bilateral wrists while working as a secretary. Electrodiagnostic studies from 8/3/12 note mild bilateral carpal tunnel syndrome affecting sensory components. Electrodiagnostic studies from 1/31/13 note bilateral median neuropathy at the wrist with denervation in the right APB muscle, and possible right cervical radiculopathy affecting C7-8 (double crush syndrome) particularly with abnormal EMG findings in the right triceps muscle. An MRI of the left wrist from 6/26/13 documents a tear of the triangular fibrocartilage complex, as well as edema and prominence of the median nerve and distension of the flexor retinaculum. Documentation from 5/31/13 notes that the patient had severe wrist/hand pain, numbness of the entire left hand, numbness and tingling of both hands, and radiating pain in her bilateral upper extremities. Phalen's test is positive and Tinel's sign is negative at the wrist. Medical reports dated 6/29/13 and 7/1/13 document that the patient has persistent numbness and tingling in the median nerve distribution and weakness of the left upper extremity, as well as decreased sensation on physical examination. The requesting surgeon states that with electrodiagnostic studies showing carpal tunnel syndrome and findings on the MRI showing edema and changes in the carpal tunnel region, left carpal tunnel release is necessary. Documentation from 9/13/13 notes the patient is wearing a brace and is using a Terocin lotion. She continues to have bilateral wrist pain that awakens her at night. She continues to have numbness and tingling in the bilateral hands, as well as weakness and radiating pain down her bilateral upper extremities. Documentation from 10/28/13 notes that the patient is using a topical analgesic of Flurbiprofen 25%, Menthol 10%, Camphor 3%, and Capsaicin 0.0375%. The patient complains of constant pain and stiffness in the neck and back. She reports that she avoids repetitive use of her hands due to continued pain, numbness and tingling. She has radiating pain

in the bilateral upper extremities associated with weakness. She has numbness and tingling over the bilateral hands. Examination documents from this time show positive Tinel's and Phalen's signs at the wrist, along with tenderness.

IMR ISSUES, DECISIONS AND RATIONALES

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

carpal tunnel surgery for the left wrist: Overturned

Claims Administrator 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-270.

Decision rationale: The patient is a 45 year old female who is documented to have continued signs and symptoms of left carpal tunnel syndrome (CTS) that has failed conservative management and that is supported by electrodiagnostic studies. As per the California MTUS/ACOEM, initial treatment of CTS should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. For patients with mild-to-moderate CTS who opt for conservative treatment, studies show that corticosteroids may be of greater benefit than nonsteroidal anti-inflammatory drugs (NSAIDs), but side effects prevent their general recommendation. The patient is documented to have used splints and had undergone activity modification. She is not documented to have used NSAIDs or corticosteroids, but as stated above, this is considered for those opt for conservative treatment. Based on the entirety of the medical record, further non-operative therapy is not warranted. The MTUS/ACOEM states that 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. Based on the above, I would assert that there is a definitive diagnosis of carpal tunnel syndrome, and any symptomatic relief with cortisone injections is not needed to facilitate the diagnosis. Her history of numbness and tingling in the median nerve distribution, examination of a positive Tinel's and Phalen's test, as well as confirmatory electrodiagnostic studies confirm her diagnosis. Typical signs associated with carpal tunnel syndrome include administration of a Katz hand diagram, Tinel's, Semmes-Weinstein, Durkan's test, Phalen's sign and square wrist sign. Two of these signs (Phalen's and Tinel's) have been documented in the records provided. The MTUS/ACOEM further states that 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. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). This patient satisfies these criteria for surgical decompression of the median nerve. She has a positive history, positive findings on physical examination, and confirmatory electrodiagnostic studies. A double crush syndrome is not documented to be present or likely on the left side. There is some question

for the right side as a cervical radiculopathy has not been ruled out. Given the overall level of documentation provided in the medical records reviewed, it is clear that the patient has left wrist carpal tunnel syndrome supported by