MAXIMUS Federal Services

Case Number:	CM13-0009867		
Date Assigned:	12/13/2013	Date of Injury:	10/14/2010
Decision Date:	02/28/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	08/12/2013

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 Recontructive 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 36 year-old female with a reported date of injury on 10/14/2010 due to 'repetitive CT injury' to both hands. She initially complained of bilateral wrist pain. She was diagnosed with bilateral carpal tunnel syndrome and had undergone right carpal tunnel release on 8/9/11 and left carpal tunnel release on 10/1/11. Follow-up from 3/25/13 notes the left palm is still tender at the base. 'The numbness is gone, but pains.' She has pain along the volar aspect of the wrist. Previous MRI from 8/30/12 notes 'a 4 x 6 mm cystic focus just proximal to the pisiform.' Return to work was documented with activity modification. Narcotic pain medication was noted. Electrodiagnostic studies dated 6/613 note patient 'presents with numbness tingling pain in the left, s/p CTS release.' Impression is documented as 'mild to moderate left carpal tunnel syndrome (median nerve entrapment at the wrist) affecting sensory and motor components.' However, the EMG component of the studies are reported to be normal. Follow-up from 7/17/2013 notes continued pain and weakness of the left wrist and continued resolution of the numbness of the hand. Return to work with activity modification was documented as well as prescriptions for narcotic pain medication and Celebrex(NSAID). Previously, she had been documented to wear bilateral hand/wrist splints at night. Based on the MRI results and EDS from 6/6/13 recommendation was made for repeat left carpal tunnel release and excision of volar wrist cyst. Evaluation dated 7/31/13 notes request for lidocaine and cortisone injection test along the median nerve of the left hand. Utilization review dated 7/25/13 reported non-certification of left open carpal tunnel release and excision of volar cyst. Reasoning was stated that for open carpal tunnel release there should be 'failure of non-operative treatment or severe symptoms such as continuous tingling and numbness, most patients should have had at least 1 glucocorticosteroid injection, and patients who do not have a glucocorticosteroid injection that results in at least partial benefit should have an electrodiagnostic study (EDS) consistent with

CTS.' 'There is no documentation of interval improvement following the first carpal tunnel release surgery on the left. It is unclear whether interval attempts at appropriate conservative care were rendered.' With respect to excision of volar cyst, 'only symptomatic wrist ganglia merit excision, if aspiration fails. However, there are not attempts at cyst aspiration. There is no evidence that the cyst is symptomatic.'

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat Left open Carpal Tunnel Release: Upheld

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 ODG (Carpal Tunnel Syndrome Chapter)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 270, 272, 273.

Decision rationale: CA MTUS has addressed Carpal Tunnel Release surgery. From page 270, 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 postsurgery 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. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. I would argue that based on the examination findings from the requesting surgeon, the patient is not documented to have definitive Carpal Tunnel Syndrome. The surgeon documents that the previously described numbness has resolved from previous carpal tunnel release, but that she had continued pain. As stated above, positive EDS in asymptomatic individuals is not CTS. On physical examination, there is no mention of thenar or intrinsic atrophy (which is generally a late sign) and weakness in the median nerve distribution is not adequately documented. Phalen's test and Tinel's sign are negative for producing median nerve numbness. EMG component of the EDS studies are reported to be normal. From page 260, CTS does not produce hand or wrist pain. From page 272, Table 11-7 injection of corticosteroids is recommended into the Carpal Tunnel in mild or moderate cases of CTS after trial of splinting and medication. This appears to have been recommended but no medical documentation exists that show any results from this treatment. From page 273, early surgical intervention may be indicated for severe CTS confirmed by Nerve Conduction Velocity test (NCV). The previous EDS had reported only mild to moderate findings, not severe and the EMG component of the study was normal. In summary, the patient's major complaints center around pain and her previous numbness is documented to have resolved. Without clear evidence of Carpal Tunnel Syndrome by history and physical examination, Carpal Tunnel Release would not be expected to treat the patient's condition of pain. In addition, the patient does not have evidence of severe Carpal Tunnel Syndrome or late signs of muscle atrophy. Thus, I would agree with the utilization review for non-certification

Excision of Volar cyst: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation ODG (Singhal, 2005) (Nielsen, 2007)

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

Decision rationale: CA MTUS ACOEM, page 271 is clear with respect to ganglia of the wrist. "Only symptomatic wrist ganglia merit or excision, if aspiration fails." As stated in the utilization review, there is no evidence of attempted aspiration of the ganglia of the left wrist. The cyst may be symptomatic and contributing to the symptomatology of the patient, but an attempt at aspiration is necessary prior to certification for surgical removal.