

<b>Case Number:</b>	CM13-0021180		
<b>Date Assigned:</b>	11/08/2013	<b>Date of Injury:</b>	06/11/2011
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2013

### 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, North Carolina, Virginia. 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 right-hand dominant 52 year old male with a work-related date of injury of 6/11/2011. He is noted to have suffered 'injury to his neck, shoulders, elbows, wrists, right hand and lower back', when a 100 pound grill landed on his right hand. He had requested right wrist carpal tunnel surgery. The patient's occupation is noted to include repetitive motions with both hands. The patient is well-documented to complain of bilateral wrist pain with numbness and tingling radiating to his fingers, specifically noted on 3/1/13. Finkelstein's causes pain; Tinel's causes radiating pain and Carpal compression causes numbness. From 8/16/13 examination, the patient is noted to complain of 'achy, right wrist pain and stiffness radiating to the hand with numbness and tingling.' Assessment by the requesting surgeon notes the patient is documented to complain of hand pain 6-7/10 as well as numbness and tingling. Examination documents bilateral positive Phalen's test, bilateral positive Tinel's sign, bilateral positive compression test in the distribution of the median nerve, bilateral mild thenar atrophy and bilateral mild abductor pollicis brevis weakness. He is documented to have undergone evaluation and management by physical therapy and chiropractor. Further documentation from 9/5/13 states that 'The patient has undergone activity avoidance for greater than 6 months, application of right nocturnal volar wrist splints for greater than 6 months, application of left nocturnal volar wrist splints for greater than two months, anti-inflammatories, home exercise treatment, physical therapy and a TENS unit.' Electrodiagnostic studies (EMG) from 5/10/13 revealed bilateral mild carpal tunnel syndrome and 'Normal EMG studies of the cervical spine...' MRI of the right wrist from 4/3/13 note fluid of the distal radius and subchondral cyst of the lunate, capitate and triquetrum.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Surgery-Carpal Tunnel Release Right Wrist: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 253-286.

**Decision rationale:** The patient is a 52 year old male with well-documented signs and symptoms of carpal tunnel syndrome. He has numbness in the classic pattern for median nerve compression at the wrist. He has pain and evidence of thenar atrophy, other signs of carpal tunnel syndrome. In addition, he has electrodiagnostic studies which confirm that he has carpal tunnel syndrome, although it is classified as mild. The UR decision dated 8/20/13 confirms that the patient has the above findings, but the reasoning for denial is based on lack of adequately-documented conservative treatment and that the severity of the carpal tunnel syndrome is unclear. Specifically, 'In general, patients without severe changes on electrodiagnostic studies require conservative treatment'. The requesting surgeon responded with further documentation on 9/5/13 of conservative treatment attempted. This included splinting, activity avoidance, physical therapy, home exercises and medications. Thus, I would argue that the failed conservative treatment is adequately documented. With respect to the severity of the carpal tunnel, I would argue that the patient's signs and symptoms of carpal tunnel are significant especially with confirmatory findings on electrodiagnostic studies, even though they were classified as mild. From American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Ch. 11, page(s) 269 Table 11-6, history and physical examination provide '++++' and '+++ ' (Number of plus signs indicates relative ability to identify or define pathology).respectively in identifying wrist/hand pathology for carpal tunnel syndrome. Electrodiagnostic studies provide '++++' as well. This defines this patient's condition as supported by the medical record and as discussed above. In addition, Table 11-1 p 255 notes red flags for severe carpal tunnel syndrome that include muscle atrophy and severe weakness of the thenar muscles. The patient has documented thenar atrophy, although mild. 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.' In my opinion and supported by the medical record this is present. However, 'surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome).' With respect to this, there is documentation that the electrodiagnostic studies that had been performed noted 'normal EMG studies of the cervical spine...' In addition, the patient had previously been treated with a neck fusion from C5 to C7. Thus, it is reasonable to suggest that there is not a double crush syndrome. In summary, the patient is well-documented to have signs and symptoms of CTS, which is confirmed on the UR from 8/20/13. He has undergone non-operative therapy and had confirmatory electrodiagnostic studies of carpal tunnel syndrome (although mild). By review of the ACOEM and