

Case Number:	CM13-0050234		
Date Assigned:	12/27/2013	Date of Injury:	09/08/2003
Decision Date:	02/28/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/11/2013

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 63 year old female with a reported date of injury of 9/8/2003. Her occupation consists of repetitive activity. She is documented to have undergone previous carpal tunnel surgery on both wrists in 2006. She has persistent numbness and tingling and had undergone cortisone injections for this, with significant improvement on the left side but not the right side. She complains of pain in her neck and shoulders at night which has been treated with acupuncture and aqua therapy. She is seeing a rheumatologist for possible inflammatory arthritis and had requested another steroid injection of her left wrist. From May 29, 2013 it is stated that she has 'some evidence on electrodiagnostic testing of some persistent/recurrent median nerve compromise at the wrist.' Examination documents 'she has parascapular and paracervical tenderness. Very mild impingement signs are seen. No other skin changes are noted. She has no atrophy.' Impression is stated as 'recurrent/persistent left carpal tunnel syndrome, status post trigger release, status post radial tunnel decompression with persistent radial tunnel syndrome symptoms on occasion, upper back and neck discomfort, cervical arthritis with possible underlying inflammatory arthritis.' The patient requested an additional steroid injection to the left wrist given her history of improvement. The physician requested authorization for a left carpal tunnel release depending upon authorization and her symptom recurrence following the injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuroplasty and/or transposition; median nerve at carpal tunnel: Upheld

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

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

Decision rationale: The patient has a history of left carpal tunnel syndrome who had undergone carpal tunnel release in 2006. She is documented to have persistent numbness and tingling. A complete examination of the hand has not been adequately documented. Typical signs associated with carpal tunnel syndrome are documented from MTUS ACOEM p. 260,261. Clinical testing may include administration of a Katz hand diagram, Tinels, Semmes-Weinstein, Durkan's test, Phalen's sign and square wrist sign. These signs have not been documented in the records provided. From MTUS ACOEM 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 post surgery 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. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). I would argue that this has not been satisfied. Electrodiagnostic studies would be critical to confirm recurrent carpal tunnel syndrome. Also, with the patient's neck and shoulder complaints, a cervical radiculopathy could be ruled out as well. The physician only states that 'She does have some evidence on electrodiagnostic testing of some persistent/recurrent median nerve compromise at the wrist.' Further specific detail has not been included which would be necessary. In addition, as stated in the UR, the patient has had a cortisone injection and no follow-up evaluation of the response was included.