

Case Number:	CM13-0053268		
Date Assigned:	12/30/2013	Date of Injury:	10/06/2009
Decision Date:	10/31/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	11/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic and Hand Surgery and is licensed to practice in Texas and Georgia. 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 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 injured worker is a 49-year-old male who reported an injury on 10/06/2009 while standing on an air compressor when he fell and injured his knees, left wrist, and low back. Diagnoses were traumatic ankle lateral collateral ligament injury with partial rupture and instability, musculoligamentous strain/sprain of the lumbar spine, discogenic disease at the L5-S1 level, multiple level discogenic disease at the cervical spine with radiculitis, left carpal tunnel-Guyon tunnel syndrome, anxiety and neurosis with insomnia, status post left knee arthroscopic surgery with residuals and recurrent tear with marked wasting of the quadriceps muscles, left ankle strain/sprain, status post traumatic fracture, left ankle, right and left shoulder impingement syndrome, subacromial bursitis, tendonitis, and left wrist sprain/strain distal radial ulnar joint with possible fracture and ligament instability. Past treatments have been medications, physical therapy, chiropractic sessions and acupuncture. Physical examination dated 04/19/2013 revealed complaints of left knee and left ankle pain. The injured worker had complaints of tingling and numbness in the left hand, mostly the ulnar 2 fingers, secondary to ulnar nerve neuritis and Guyon tunnel condition. The injured worker reported that the left ankle was unstable and it would give out on him, and it also cracked. It was reported that recently the cracking had increased. An unofficial MRI of the left ankle from 2011 revealed strain and ligamentous partial tear of the anterior talofibular ligament, posterior talofibular ligament, and calcaneofibular ligament. Physical examination revealed tenderness to palpation behind the fibula head. The injured worker also shoots in the front of the leg from the time of the knee surgery. The injured worker had significant weakness of the left ankle when walking. With palpation, there was tenderness to palpation around the fibula head and also 4- strength of quadriceps muscles as well as 4- strength of the extensors. The injured worker had bilateral hammertoe deformity that seemed to be nonindustrial. The injured worker also had a tight ankle. Range of motion on

dorsiflexion of the left ankle was to 15 degrees and plantarflexion was to 20 degrees, eversion was 10 degrees, and inversion was to 20 degrees. There was pain behind the fibular head over the lateral collateral ligaments. The injured worker had slight hypoesthesia over the anterolateral aspect of the leg, but not in the dorsum of the foot. As of 05/24/2013, the injured worker reported the inability to move his left ankle at full ranges and experiencing a significant amount of pain. Objective findings included decreased range of motion and strength with plantar and dorsiflexion. There was tenderness over the anterior talofibular ligament and a little bit of laxity. Neurological examination revealed decreased sensation over the hands as well as over the arms. Examination of the left wrist noted slight decreased sensation over the thumb and index finger with decreased grip strength. There was also significant tenderness over the dorsal aspect at the ulnar styloid. The treatment plan noted the injured worker was pending authorization for left ankle arthroscopic examination and surgery. It was noted he had already undergone all conservative modalities. The provider requested an extension on the Chrisman-Snook procedure. The injured worker received refills of Prilosec, Tramadol, and Senokot. The rationale and request for authorization were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

LT CARPAL TUNNEL RELEASE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The California MTUS/ACOEM Guidelines state surgical decompression of the median nerve usually relieves carpal tunnel symptoms. High quality scientific evidence showed success in the majority of injured workers with an electrodiagnostically confirmed diagnosis of carpal tunnel syndrome. Injured workers with the mildest symptoms display the poorest postsurgery results, injured workers with moderate or severe carpal tunnel have better outcomes from surgery than splinting. Carpal tunnel must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve conduction test before surgery is undertaken. Mild carpal tunnel with normal electrodiagnostic studies exists, but moderate or severe carpal tunnel with normal electrodiagnostic studies is very rare. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Referral for hand surgery consultation may be indicated for injured workers who have red flags of a serious nature, fail to respond conservative management, including worksite modifications, and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The injured worker's examination of the left wrist noted slight decreased sensation over the thumb and index finger with decreased grip strength. There was also significant tenderness over the dorsal aspect at the ulnar styloid. There is a lack of documentation regarding positive Phalen's or Tinel's tests. There is no indication of failed conservative measures for the left hand/wrist. The injured worker did not have any official electrodiagnostic studies submitted to confirm the diagnosis of carpal tunnel syndrome. The

injured worker does not meet the criteria for the requested surgery at this time. Therefore, this request is not medically necessary.