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| <b>Case Number:</b>   | CM14-0170359 |                              |            |
| <b>Date Assigned:</b> | 10/20/2014   | <b>Date of Injury:</b>       | 04/01/2013 |
| <b>Decision Date:</b> | 12/19/2014   | <b>UR Denial Date:</b>       | 09/11/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/15/2014 |

### 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 Physical Medicine & Rehabilitation and is licensed to practice in California. 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 female who reported injury on 04/01/2013. The mechanism of injury was not submitted for this review. The injured worker's treatment history included left carpal tunnel release and excision of volar ganglion cyst on 07/08/2013. EMG/NCV studies of the left upper extremity on 02/12/2014 that revealed complaints of moderate left CTS (prolonged left median, motor and sensory latencies) without evidence of active muscle denervation (normal EMG). An EMG/NCV study was done on 05/29/2013 prior to the left open carpal tunnel release and were essentially unchanged from the prior study done on 02/12/2014. Other therapies included left elbow surgery done on 05/30/2014, physical therapy, and medications. The injured worker was evaluated on 08/13/2014 and it was documented the injured worker was there for re-evaluation of her left elbow and left wrist. The injured worker states that she was doing okay. The numbness and tingling in the ring and small finger had improved. Unfortunately, the numbness and tingling in the median nerve distribution was getting progressively worse. Physical examination of the left elbow showed a well healed scar. Gross neuro was intact to both motor and sensation. She does have good range of motion. Physical examination of the left wrist showed well healed scar. She had a positive Tinel's at the wrist and a positive Phalen's. The treatment plan included authorization request for revision left open carpal tunnel release with hypothenar flap. The provider noted she had failed conservative management including time, physical therapy and splinting. The injured worker was evaluated on 09/16/2014 and it was documented the injured worker was status post left elbow surgery done on 05/30/2014. She was continuing to have numbness and tingling in the left hand and the median nerve distribution as well. Physical examination of the left hand revealed positive Tinel's, Phalen's and Durkan's. There was no thenar atrophy. The scars looked well healed. There was no redness and no swelling and no tenderness. Diagnoses included left open carpal tunnel release in 2013, left

subcutaneous ulnar nerve transposition, right open carpal tunnel release, and left volar carpal ganglion. Request for authorization dated 08/13/2014 was for left wrist revision, open carpal tunnel release, with hypothenar flap.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left wrist revision, open carpal tunnel release with hypothenar flap: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines Carpal Tunnel Syndrome. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Release

**MAXIMUS 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 (ODG) Carpal Tunnel Syndrome. Carpal Tunnel Release Surgery (CTR).

**Decision rationale:** The request for left wrist revision, open carpal tunnel release with hypothenar flap is medically necessary. CAMTUS/ACEOM 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. 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). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression. Risks of surgical decompression include complications of anesthesia, wound infection, and damage to the median nerve. Incomplete decompression or recurrence of symptoms can lead to the need for further surgery. Based on the data from the randomized controlled trials, endoscopic carpal tunnel release seems to be an effective procedure compared to open surgery; however, greater emphasis must be given to training surgeons in this technique to avoid major complications such as median nerve injuries. With proper training and equipment, endoscopic carpal tunnel release can be done safely, with complication rates comparable to those for the open technique and with high patient satisfaction. Early return to work after either type carpal tunnel surgery is more dependent on the willingness of the employer and patient than on the surgical technique. Two prospective randomized studies show no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home therapy program. The Official Disability Guidelines (ODG) state that Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. See Severity definitions. Carpal

tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. The documents submitted for review indicated there was no indication precisely when the injured worker's symptoms returned or whether they were in fact ongoing. The most recent progress report dated on 08/13/2014, noted the numbness and tingling in the ring and small finger had improved but the numbness and tingling in the median nerve distribution was getting progressively worse. The neurological examination was grossly intact for motor and sensation. There was good range of motion and a positive Tinel's and Phalen's. Electrodiagnostic testing showed evidence of distal left median compressive neuropathy. The documents submitted for review the provider indicated the injured worker has failed splinting, time, and other conservative care measures and the injured worker's symptoms were essentially getting worse. Moreover, the electrodiagnostic studies would not confirm the problem if it is recurrent unless the injured worker had improvement. Therefore, per the guidelines the request for left wrist revision, open carpal tunnel release with hypothenar flap is medically necessary.

**1 assistant surgeon:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid Services (CMS)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic. Surgical Assistant.

**Decision rationale:** The request for 1 assistant surgeon is medically necessary. The Official Disability Guidelines (ODG) state that surgical assistant is recommended as an option in more complex surgeries as identified below. An assistant surgeon actively assists the physician performing a surgical procedure. Reimbursement for assistant surgeon services, when reported by the same individual physician or other health care professional, is based on whether the assistant surgeon is a physician or another health care professional acting as the surgical assistant. Only one assistant surgeon for each procedure is a reimbursable service, without exceptions for teaching hospitals or hospital bylaws. The request for 1 assistant surgeon is medically necessary to perform procedure left wrist revision, open carpal tunnel release with hypothenar flap. As such the request is medically necessary.