

Case Number:	CM14-0176503		
Date Assigned:	10/29/2014	Date of Injury:	03/01/2014
Decision Date:	12/05/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/24/2014

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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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 patient is a 58 year old male with a reported date of injury on 3/1/14 who requested right carpal tunnel release. Initial spine evaluation dated 9/30/14 notes chief complaint of neck pain, pain in the left shoulder and wrists. His neck pain radiates to his shoulders, arms and ulnar border of forearms and long fingers. He has numbness in the same distribution. He denies weakness of the upper extremities. He has pain in both hands and wrists. He wakes up at night having to shake his hands. Treatment has included physical therapy, chiropractic manipulation and wearing splints. Splints have not helped his wrists. Examination notes sensation is intact to light touch and pin prick in all dermatomes in the bilateral upper extremities. Two-point discrimination is within normal limits. Motor tests are normal. Tinel's and Phalen's are reported as normal. Electrodiagnostic studies are stated to show moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome. MRI is stated to show cervical stenosis. Diagnoses include bilateral carpal tunnel syndrome, cervical stenosis, radiculitis and rotator cuff tendinitis. Recommendation is to perform right sided carpal tunnel release first. Integrated Pain Care dated 9/26/14 notes diminished sensation in the left C5 and bilateral C6-C7 dermatomes of the upper extremities. Diagnoses include severe cervical stenosis, radiculopathy, shoulder strain and herniated disc. Recommendation is made for Neurontin for neuropathic pain and referral for surgical spine evaluation. Physical therapy treatment is documented. The patient is noted to complain of cervical spine pain with radiating numbness and tingling to bilateral upper extremities with any neck motion or use of the upper extremities. Progress report dated 9/8/14 notes follow-up for neck pain. He continues with neck pain and has been undergoing modified work duty. His pain is associated with radicular symptoms of pain, numbness and tingling down the bilateral C6 dermatomal distributions to the level of the thumbs. He has treated his pain with Ultracet, resting and stretching. He has been undergoing physical therapy. Examination notes

sensation is reduced to light touch in the bilateral C6 dermatomal distributions. Spurling's maneuver reproduces the patient's numbness, tingling and pain. Diagnoses include neck pain with bilateral C6 radiculopathy and left rotator cuff impingement syndrome. Possible epidural steroid injection was discussed with the patient and referral for spine evaluation. The patient is to continue with Ultracet and activity restrictions. Integrated Pain Care initial evaluation dated 8/29/14 notes diagnoses of severe cervical stenosis, radiculopathy, shoulder sprain and herniated disc. Recommendation is for continued conservative management of the neck pain. Physiatry evaluation dated 8/4/14 notes the patient with neck pain, left shoulder pain and bilateral hand numbness and tingling. He has undergone chiropractic treatment with some success. The patient has radicular symptoms of pain, numbness and tingling down the left C6 dermatomal distribution. Sensation to light touch is slightly reduced in the left thumb compared to the right. The patient is diagnosed with cervical degenerative disc disease, left C6 radiculopathy, left rotator cuff impingement syndrome and bilateral carpal tunnel syndrome. Carpal tunnel braces were given to be used at night. A left C6 epidural steroid injection was considered. Electrodiagnostic studies dated 7/8/14 note moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome. Utilization review dated 10/9/14 did not certify the procedure of right carpal tunnel release, post-operative physical therapy x 12 and cold therapy. Reasoning given was that there was a lack of documentation showing that the patient met all of the criteria for which a carpal tunnel release would be supported, based on ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right 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 Official Disability Guidelines (ODG), Carpal Tunnel, Carpal Tunnel Release

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

Decision rationale: The patient is a 58 year old male with some signs and symptoms consistent with a possible right carpal tunnel syndrome. The patient had previously undergone electrodiagnostic testing which demonstrated bilateral carpal tunnel syndrome, with moderate severity on the right. The patient has complicating factors of possible bilateral radiculopathy of C6-C7 based on signs and symptoms from multiple evaluations. From ACOEM, page 270, Referral for hand surgery consultation may be indicated for patients who:- Have red flags of a serious nature- Fail to respond to conservative management, including worksite modifications- 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 patient is not documented to have red flags of a serious nature including but not limited to thenar atrophy, which could necessitate more urgent surgical treatment. The patient has undergone some conservative management including activity modification, medical therapy, physical therapy and bracing. However, based on the evaluation from the requesting surgeon, a clear clinical picture of right carpal tunnel syndrome is not present. Further from ACOEM, page 270, CTS (carpal tunnel syndrome) 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. From the requesting surgeon's evaluation on 9/30/14, he notes more pain symptoms consistent with a radiculopathy in which the sensory disturbance follows the same pattern of distribution. His symptoms do wake him at night as he has to shake his hands. He does have electrodiagnostic studies that support a right carpal tunnel syndrome. However, his clinical examination does not provide supporting documentation. Examination notes sensation is intact to light touch and pin prick in all dermatomes in the bilateral upper extremities. Two-point discrimination is within normal limits. Motor tests are normal. Tinel's and Phalen's are reported as normal. Thus, based on the examination, there is not a clear picture of right carpal tunnel syndrome and carpal tunnel release should not be considered medically necessary. In addition, the UR documents ODG guidelines which also do not support that right carpal tunnel release is medically necessary.

Associated surgical service: post-op physical therapy 2 x 6: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: cold therapy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.