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| Case Number: | CM14-0185757 | | |
| Date Assigned: | 11/13/2014 | Date of Injury: | 08/04/2009 |
| Decision Date: | 12/15/2014 | UR Denial Date: | 10/22/2014 |
| Priority: | Standard | Application Received: | 11/07/2014 |

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 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 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 56 year old male with a reported date of injury on 8/4/09 who requested a left carpal tunnel release. Documentation from the requesting surgeon dated 1/22/14, notes that the injured worker had complained of bilateral hand numbness and tingling over the past several months. Previous treatment had included night splinting. Examination notes no evidence of intrinsic atrophy; but with decreased sensation in the median nerve distribution and a positive carpal compression test. Electrodiagnostic studies were stated to be consistent with bilateral carpal tunnel syndrome. Recommendation was made for left carpal tunnel release. No further medical records were provided for review, except for summaries from the UR of visit dates on 7/22/14 and 10/2/14, as well as electrodiagnostic studies from 10/28/13. From the electrodiagnostic studies, the injured worker is stated to have moderate right carpal tunnel syndrome and mild left carpal tunnel syndrome, as well as bilateral C6 radiculitis. From the 7/22/14 progress report (not from the requesting surgeon), the injured worker is stated to have positive Phalen's (R>L) and diagnosis of carpal tunnel syndrome and bilateral C6 radiculitis among other diagnoses. Recommendation was made for referral to hand surgery for evaluation of right hand pain. Documentation from the requesting surgeon dated 10/2/14, the injured worker is stated to have continued complaints of bilateral hand numbness and tingling. Objective findings include positive carpal compression test and decreased sensation in the median nerve distribution. Recommendation was made for left carpal tunnel release. UR review dated 10/22/14 did not certify a left carpal tunnel release. Reasoning given was that based on evaluation of the medical records, there were inconsistent reports of more right-sided clinical carpal tunnel syndrome symptoms and worse right sided electrodiagnostic study findings. There was insufficient documentation to clarify what functional deficits can be ascribed to left carpal tunnel syndrome symptoms to warrant surgical intervention. Finally, there

was insufficient documentation of a failure to respond to conservative measures such as physical therapy or a trial of corticosteroid injection before surgery is considered. The UR did document that the injured worker had undergone conservative management of splinting, NSAIDs, opioids and activity restrictions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. 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, 272-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Release, Indications For Surgery

Decision rationale: From 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). Thus, the bilateral C6 radiculitis should be addressed in some fashion. The injured worker does have signs and symptoms of bilateral carpal tunnel syndrome that has failed some conservative management. However, the supportive electrodiagnostic studies were from a year ago and only showed mild findings on the left side. In addition, from page 272, Table 11-7, recommendations are made with respect to mild and moderate carpal tunnel syndrome. Injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after a trial of splinting and medication is recommended. The injured worker has not been considered for steroid injection. Finally, early surgical intervention for severe CTS confirmed by NCV may be indicated. The injured worker is not documented to have severe carpal tunnel syndrome and thus early surgical intervention is not indicated. In summary, the injured worker is documented to have signs and symptoms of possible bilateral carpal tunnel syndrome. The supportive electrodiagnostic studies are from a year ago and they are only stated to show a mild condition on the left. It is not clear why the left side was chosen and needs greater clarification/justification prior to intervention. Conservative management had been documented, except for steroid injection as recommended by the ACOEM. There is no evidence of a severe condition. Therefore, the request for Left Carpal Tunnel Release is not medically necessary.