Case Number:	CM14-0028843		
Date Assigned:	06/02/2014	**Date of Injury:**	08/18/2011
Decision Date:	07/23/2014	**UR Denial Date:**	01/09/2014
Priority:	Standard	**Application Received:**	01/16/2014

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 68 year old male with a reported date of injury on 8/18/11. He had previously undergone left shoulder surgery and later hardware removal with postoperative physical therapy. Electrodiagnostic studies from 8/14/13 note left ulnar neuropathy across the elbow and minimal left carpal tunnel syndrome. Documentation from the primary treating physician on 9/11/13 notes the patient has signs and symptoms of left cubital tunnel syndrome at the elbow. Documentation from this same physician on 10/18/13 notes cubital tunnel syndrome. He states he still feels numbness along the 3rd, 4th and 5th fingers. He is stated to have undergone injection to the left elbow and was provided splints for use during the day and night. Documentation from the requesting hand surgeon on 12/5/13 notes the patient underwent left wrist cortisone injection without improvement and did not have a cubital tunnel brace. He has numbness in all the digits. Examination notes negative for Tinel and ulnar nerve subluxation, but positive direct compression hyperflexion test at the left cubital tunnel. A left carpal tunnel exam was negative for Tinel and positive direct compression for Phalen. Discussion notes the cortisone injection did not result in improvement. A cubital tunnel brace was provided but was not likely to improve the condition. Recommendation was made for carpal tunnel release and cubital tunnel release at the elbow. In addition, electrodiagnostic studies reveals minimal carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

ENDOSCOPIC LEFT CARPAL TUNNEL RELEASE, POSSIBLE OPEN: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 253-279.

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

Decision rationale: The patient is a 68 year old male who had requested left carpal tunnel release. By review of the medical records provided, the patient does not have clear indication for surgical carpal tunnel release. The majority of his symptoms appear related to a left ulnar neuropathy at the elbow and not a left median neuropathy at the wrist. Electrodiagnostic studies from 8/14/13 only note a minimal left carpal tunnel syndrome at the wrist. The patient is not documented to have undergone bracing of the left wrist. The primary treating physician appears to note cortisone injection of the left cubital tunnel, whereas the hand surgeon notes cortisone infection of the left wrist. A home exercise program, worksite modifications or physical therapy has not been documented. Referring to the ACOEM Guidelines, page 270, the patient is not documented to have red flags of a serious nature, including but not limited to thenar atrophy or weakness. There is insufficient documentation of conservative measures that have been attempted prior to recommendation for surgical intervention. Nor has the patient undergone splinting of the left wrist. Further from page 270, patients with the mildest symptoms display the poorest post surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. The patient is noted to have only a minimal carpal tunnel syndrome from electrodiagnostic studies. No previous documentation of conservative measures attempted is included for review, except for possible steroid injection (although the medical records are not consistent). From page 271, Table 11-7, recommendations are made for the evaluation and treatment of carpal tunnel syndrome. Initial therapy includes splinting as first-line conservative treatment. Injection of corticosteroids into the carpal tunnel in mild or moderate cases of CTS after trial of splinting and medication is recommended. As stated above, this has not been adequately documented. In summary, the patient has signs and symptoms of minimal left carpal tunnel syndrome without red flags of a serious nature. There has been insufficient documentation of conservative measures. The majority of the patient's functional problem appears to be related to an ulnar neuropathy and not a median neuropathy. Based on a minimal carpal tunnel syndrome, a well-documented conservative trial is indicated prior to surgical intervention. Thus, left carpal tunnel release is not medically necessary.