

<b>Case Number:</b>	CM14-0030520		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/13/2012
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 60-year-old female who reported injury on 08/13/2012. The specific mechanism of injury was not provided. Other treatments included physical therapy, night bracing, and a right carpal tunnel release. The documentation of 02/03/2014 revealed the injured worker was complaining of pain and numbness in her left hand. The injured worker had increased night time numbness. It was noted the injured worker shakes her hand because of her symptoms. The physical examination revealed tenderness at the left trapezius and a positive Phalen's and Tinel's in the left wrist. The injured worker had decreased sensation involving the median nerve distribution on the left. Weakness of the thumb abductors was present. The diagnoses include carpal tunnel syndrome bilaterally and status post carpal tunnel release on the right. The treatment plan included a left carpal tunnel release. It was indicated the injured worker underwent an electrodiagnostic evaluation consistent with moderate carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Surgical procedure: Carpal Tunnel Release (left): 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, Carpal Tunnel Syndrome chapter.

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

**Decision rationale:** The ACOEM Guidelines indicate that carpal tunnel syndrome must be proven by positive findings on clinical examination and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. The injured worker had objective findings on physical examination. The clinical documentation submitted for review indicated the injured worker had positive electrodiagnostic testing; however, the official results were not provided for review. Given the above, and the lack of documentation, the request for a carpal tunnel release is not medically necessary.

**Twelve (12) sessions of post-op physical 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.

**Pre-operative clearance:** 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.

**Cold Therapy Unit (two (2) week rental):** 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.