MAXIMUS Federal Services

Case Number:	CM14-0039601		
Date Assigned:	06/27/2014	Date of Injury:	03/15/2012
Decision Date:	07/29/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/04/2014

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, North Carolina, and 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 patient is a 59-year-old female with a reported date of industrial injury on 3/15/12. A request was made for left carpal tunnel release. Previously, the patient had undergone left carpal tunnel release on 11/15/12 and right carpal tunnel release on 1/9/14. Electrodiagnostic studies from 8/5/13 note no evidence of left carpal tunnel syndrome, but rather left C6/7 mild nerve roots irritation that does not meet criteria for cervical radiculopathy. Documentation from 11/26/13 notes recurrent left carpal tunnel syndrome and right carpal tunnel syndrome. Recommendation was made for right carpal tunnel release, but it was noted on the documentation that "I do not advise surgery on the left" based on normal electrodiagnostic studies for the left side. Documentation from 1/20/14 notes that the patient was seen in follow-up after right carpal tunnel release and described continued pain of the left hand and shoulder. Documentation from 1/28/14 notes the patient's history included electrodiagnostic studies from 6/28/12 noting left carpal tunnel syndrome and suggestion of chronic left C5-6 and C6-7 radiculopathy. Due to continuing symptoms and lack of improvement from non-operative therapy, the patient underwent further electrodiagnostic studies on 8/5/13. Examination revealed "Tinel's and Phalen's were positive at bilateral wrists." Assessment noted persistent residual pain and paresthesia following her left carpal tunnel release, as well as bilateral lateral epicondylitis and wrist tendinitis. She was instructed to continue Neurontin and Motrin, a home exercise program and total temporary disability due to her recent surgery. Documentation from 2/7/14 notes she has numbness in the left hand. There is decreased sensation over the left middle and ring fingers. Tinel's and Phalen's are positive. Assessment is recurrent left carpal tunnel syndrome and recommendation is for exploration of the median nerve. Documentation from 3/3/14 notes findings and recommendations similar to those of 1/28/14. From a PR-2 dated 3/3/14, she is stated to have a diagnosis of left recurrent carpal tunnel syndrome despite normal

nerve conduction studies. Recommendation was made for exploration of the left median nerve. A utilization review dated 3/21/14 did not certify left carpal tunnel release. The reasoning given was that the patient had previously undergone left carpal tunnel release with return of symptoms. Additionally, electrodiagnostic studies from 8/5/13 were normal for the left side. The utilization review determination states, "While it is appreciated that her symptoms have started to recur, it remains relevant that the patient has not undergone a recent course of conservative treatment to the left wrist and hand including splinting, injections and therapy. Given the negative electrodiagnostic studies along with the lack of recent conservative treatment, the proposed surgical intervention would not be indicated."

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 Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The patient is a 59-year-old female with recurrent signs and symptoms of median nerve irritation of her left hand in the setting of previous left carpal tunnel release. However, electrodiagnostic studies demonstrate normal findings relative to the median nerve at the left wrist. There is some mild C6/7 nerve root irritation that does not satisfy criteria for radiculopathy. As stated in the utilization review, although the recurrent signs and symptoms are noted, there is no confirmatory evidence from the electrodiagnostic studies. According to page 270 of ACOEM, "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, such as thenar atrophy. A recent course of conservative management, including splinting, injection, and physical therapy, has not been documented. Without confirmatory findings on electrodiagnostic studies, and without documented failure of non-operative therapy, the patient does not have a clear evidence of nerve entrapment of the wrist. Other etiologies must be considered. Although the electrodiagnostic studies did not diagnose a cervical radiculopathy specifically, this may be contributing to a possible double crush syndrome. Again, from page 270 of ACOEM, "Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome)." Furthermore, "Surgical decompression of the median nerve usually relieves CTS (carpal tunnel syndrome) 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 from 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." As stated, CTS diagnosis should be supported by nerve-conduction tests before surgery is undertaken. This is not the case for this patient. In summary, without confirmatory evidence from electrodiagnostic studies and without a recent trial of non-operative therapy, surgical intervention to explore the median nerve at the wrist is not medically necessary at this time.