

Case Number:	CM14-0040158		
Date Assigned:	06/27/2014	Date of Injury:	03/22/2013
Decision Date:	07/23/2014	UR Denial Date:	03/20/2014
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, 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 39-year-old female with a reported date of injury on 3/22/13. The patient requested authorization for right carpal tunnel release. The documentation from 6/3/14 notes the patient has persistent pain of the right wrist. As there is no available modified work, the patient remains off work. She complains of intermittent numbness and tingling to the right wrist. She uses a brace that is sometimes helpful. The patient has numbness of the radial three digits of the right hand. On examination, carpal tunnel compression reproduces numbness. Phalen's test reproduces numbness. Tinel's test produces pain. Thenar atrophy is not present but thenar weakness is present. On assessment, the patient is noted to have a right triangular fibrocartilage complex (TFCC) tear confirmed by MRI (magnetic resonance imaging), mild ulnar positive variance and mild right carpal tunnel syndrome confirmed by electrodiagnostic studies. The plan was for treatment of the TFCC tear and release of the right carpal tunnel at the same time. The patient is also noted to have been taking NSAIDs for medical management of wrist pain. documentation from Qualified Medical Evaluation from 5/1/14 notes an assessment of mild bilateral carpal tunnel syndrome, 'particularly symptomatic on the right.' The symptoms documented that included paresthesias of the right hand. Previous non-operative therapy has included physical therapy and steroid injection. The report of 2/27/14 notes 'Ongoing problems with numbness and tingling and achiness. Wakes her up at night.' The documentation from 4/22/14 notes patient has continued numbness and tingling. Physical therapy has been done. 'She braces for hand that night.' She has modified her activity and previous steroid injection to the distal ulnar area provided temporary relief. Reasoning for performing carpal tunnel release at the same time of the TFCC surgery was stated that wrist surgery could worsen the carpal tunnel syndrome already present. Electrodiagnostic studies from 12/24/13 confirm mild bilateral carpal tunnel syndrome. Further follow-up documentation is consistent with carpal tunnel syndrome

that has failed non-operative management and confirmed by electrodiagnostic studies. Utilization review dated 3/20/14 did not certify the procedure of carpal tunnel release. Reasoning given that despite electrodiagnostic studies documenting mild right carpal tunnel syndrome, the patient's objective findings and documentation of non-operative measures are not sufficient to warrant surgical release of a mild carpal tunnel syndrome. The last documented follow-up note reviewed was from 2/26/14. Specific documentation lacking was the following: No documentation of nighttime awakening, nocturnal paresthesias, positive flick test, and no documentation of Katz hand diagram, two-point discrimination and or Semmes-Weinstein testing. There was no note of thenar atrophy. There was no documentation of hand positional sensory changes and no documentation of wrist splinting either during day or night. There was no documentation of the details of conservative care to date to include splinting, carpal tunnel injection or physical therapy. The provider noted since he was taking the patient for TFCC surgery he would release the carpal tunnel. 'I noted that this was a very mild carpal tunnel syndrome (CTS) and there were no treatments rendered for this diagnosis.'

IMR ISSUES, DECISIONS AND RATIONALES

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

CARPAL TUNNEL RELEASE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 263, 270, & 272.

Decision rationale: By review of the entirety of the medical record, the patient has well-documented mild carpal tunnel syndrome that has failed conservative measures and is confirmed by electrodiagnostic studies. According to the ACOEM guidelines, surgical decompression of the median nerve usually relieves carpal tunnel syndrome (CTS) symptoms. High-quality scientific evidence shows success in the majority of patients with an electro-diagnostically 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. In addition, the ACOEM guidelines also indicate that initial injection of steroid is indicated for mild or moderate cases of CTS after a trial of splinting and medication. As stated, CTS must be proved by positive findings on clinical examination and should be supported by nerve-conduction studies. This has been documented for this patient. There were more recent follow-up examinations that were not available to the initial peer reviewer to support the clinical exam findings of CTS that have failed non-operative measures. The patient is noted to have nighttime paresthesia, has undergone splinting and previous steroid injection and has thenar weakness. The patient is documented to

have undergone a steroid injection either at the carpal tunnel or in the area of the ulnar complaints. The patient is noted to have undergone bracing and thus prolonged bracing would not be indicated. Nerve conduction studies are indicated after failure of conservative management but not as a screening tool. The patient has documented failure of conservative management and thus the electrodiagnostic studies performed support the diagnosis consistent with the medical record. Moreover, positive findings from a carpal tunnel compression test, Phalen's sign and Tinel's sign are documented. The patient has been treated with non-steroidal anti-inflammatory drugs (NSAIDs), previous physical therapy and worksite modifications without long-term success. Activity modification is indicated for carpal tunnel surgery as well as nighttime splinting. As stated above, this has been documented as the patient has not returned to work as there is not available modified duty. Clinical testing may include a Katz hand diagram, Tinel's sign, Semmes-Weinstein, Durkan's, Phalen's and square wrist. Physical examination, history and electrodiagnostic studies provide the highest ability to determine carpal tunnel syndrome. As reasoned above, the patient's medical documentation as reported on more recent documentation (not available to the initial utilization reviewer) support that the patient has mild carpal tunnel syndrome from examination and history findings, failed conservative measures of splinting, work modification, steroid injection and NSAIDs and has confirmatory electrodiagnostic studies. The most recent medical documentation sufficiently addresses the concerns of the initial reviewer. Thus, based on the ACOEM guidelines, the request for carpal tunnel release is medically necessary and appropriate.