

Case Number:	CM14-0069781		
Date Assigned:	07/14/2014	Date of Injury:	04/04/2012
Decision Date:	08/27/2014	UR Denial Date:	05/07/2014
Priority:	Standard	Application Received:	05/15/2014

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 Surgery and is licensed to practice in Oregon. 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:

This patient is a 44 year old, right hand dominant, female who complained of right wrist pain since April 4, 2012 after working on her computer. At the initial visit with [REDACTED] on June 3, 2012, she complained of pain and fatigue of her right hand. Work activities and splinting increased her symptoms. On exam, she had tenderness of the flexor carpi radialis (FCR) and had positive Tinel and Phalen's tests, Range of motion was full, and [REDACTED] diagnosed the patient with possible atypical carpal tunnel syndrome and injected the carpal tunnel with corticosteroid. An X-ray of the right wrist was normal. At the July 3, 2012 visit, she stated the injection had made her symptoms worse. Her main complaint was still pain, but she also had occasional tingling. On exam, there was tenderness over the FCR and the flexor carpi ulnaris. Tinel and Phalen's tests were positive, her x-rays showed a possible cyst in the dorsal aspect of the scapholunate Ligament. A request for an MRI to rule out possible occult ganglion putting pressure on the median nerve and tendons was approved on July 17, 2012. The patient was seen on November 5, 2012 by [REDACTED]. At that time, she complained of wrist and hand pain, right side, she had a positive Tinel and positive cubital tunnel sign. On November 14, 2013, she was seen in follow up by [REDACTED] for increasing pain. He noted that she was considered permanent and stationary and that she had therapy and medications as needed. On January 30, 2014, the patient was seen by [REDACTED]. At that time, she noted that she had increasing symptoms in the palmar and radial aspects of the right forearm; she had a positive Tinel and Phalen signs. She had tenderness over the carpal canal, [REDACTED] injected her carpal tunnel area on that date. The patient was seen again by [REDACTED] On April 25, 2014. At that time, she had positive Tinel's, Phalen's and Durkan's tests. She had some slight symptoms associated with neck activity; [REDACTED] opined that the patient had acute carpal tunnel and radial tunnel. This is a request for authorization for a carpal tunnel release on the right.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Carpal Tunnel Chapter.

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

Decision rationale: The carpal tunnel release is not medically necessary. According to the ACOEM guidelines, Chapter 11, 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. This patient had a nerve conduction test but the records do not document the results of the test. In addition, her first steroid injection worsened her symptoms and the results of the repeat steroid injection are not documented. Per the ACOEM guidelines, carpal tunnel release is not medically necessary.

Physical therapy post-operative and occupational therapy 2-3 times per week for 12 visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Carpal Tunnel Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Postoperative therapy Carpal Tunnel Release.

Decision rationale: Per MTUS, only 8 visits are allowed following carpal tunnel release. In addition, the carpal tunnel release is denied and therefore there is no indication for therapy.