

Case Number:	CM14-0092300		
Date Assigned:	07/25/2014	Date of Injury:	02/13/2012
Decision Date:	08/28/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/18/2014

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 52-year-old female with a reported date of injury on 2/13/12 who requested left carpal tunnel release. Documentation from 4/22/14 notes pain in the neck, bilateral shoulders and wrists. The patient has 'bilateral wrist complaints with repetitive movements' and symptoms are awakening her at night. She is wearing bilateral wrist supports. Thenar atrophy is documented of the right wrist. Phalen's sign and Tinel's sign is positive on the right. Grip strength is symmetric bilaterally at 60 kg by Jamar dynamometer. Abductor pollicis brevis is noted to have 5/5 strength bilaterally on motor exam. Assessment is bilateral carpal tunnel syndrome and plans for right carpal tunnel release followed by left carpal tunnel release, pending authorization. The patient is to continue a home-based exercise program and to continue wearing wrist supports. In addition, the patient has cervical spine disc protrusion at C5-7 with neural foraminal stenosis and bilateral upper extremity radiculitis (among other diagnoses). Documentation from 3/25/14 notes radiation of neck pain along the upper extremities and numbness of the bilateral wrists, which awakens her at night. The patient continues to wear bilateral wrist supports. Grip strength is noted to be 24 kg on the right and 18 kg on the left by Jamar dynamometer on the third attempt. Abductor pollicis brevis is 5-/5 on motor exam. Assessment is that bilateral carpal tunnel release is requested based on failure of conservative measures. In addition, the patient has cervical spine disc protrusion at C5-7 with neural foraminal stenosis and bilateral upper extremity radiculitis (among other diagnoses). Documentation from 2/11/14 notes bilateral wrist pain and stated bilateral carpal tunnel syndrome. Grip strength is symmetric bilaterally at 31 kg by Jamar dynamometer at fourth attempt. "I am requesting authorization for bilateral carpal tunnel based on the recommendations" from a 10/21/13 report. Neurology documentation notes the patient with complaints of paresthesias and decreased sensation to the bilateral hands. Documentation from 1/7/14 notes the patient complains of bilateral wrist pain, as well as neck and bilateral

shoulder pain. Abductor pollicis brevis is noted to have 5-/5 strength on motor exam. Documentation from 11/26/13 notes the patient has pain of the neck, bilateral shoulders and wrists. Abductor pollicis brevis is noted to have 5-/5 strength on motor exam. Documentation from 10/29/13 notes the patient complains of pain in the neck, bilateral shoulders and wrists. The patient had previously undergone right shoulder surgery. Grip strength is 20 kg bilaterally by Jamar dynamometer. Abductor pollicis brevis is 5-/5 on motor exam. Patient is diagnosed with cervical spine disc protrusion at C5-7 with neural foraminal stenosis, bilateral upper extremity radiculitis and bilateral carpal tunnel syndrome (among others). Documentation from 10/1/13 notes electrodiagnostic studies from 7/2/12 were performed due to decreased sensation to the right arm with weakness to the right greater than the left. "Electromyography (EMG) and nerve conduction velocity (NCV) findings: 1) the right ulnar motor nerve showed reduced amplitude and decreased conduction velocity. 2) All remaining nerves were within normal limits. 3) All exam of the muscle showed no evidence of electrical instability." Documentation from 5/28/13 notes current complaints of neck, right shoulder and back pain with a stated diagnosis of bilateral carpal tunnel syndrome. Motor strength is noted to be 5/5 for bilateral finger abduction and abductor pollicis brevis. Utilization review dated 5/27/14 did not certify left carpal tunnel release stating that there was insufficient examination documentation to warrant carpal tunnel release. On left, thenar atrophy is present, but Phalen and Tinel are not mentioned. Sensation and strength are not mentioned on either side. The location of the paresthesias or pain is not specified.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation S. Terry Canale, and James H. Beaty Campbell's Operative Orthopaedics , Twelfth Edition. Copyright © 2013 by Mosby, an imprint of Elsevier Inc. Chapter 76 'Carpal Tunnel Syndrome, Ulnar Tunnel Syndrome, and Stenosing Tenosynovitis', pages, 3637-3660.

Decision rationale: The patient is a 52-year-old female with a stated diagnosis of bilateral carpal tunnel syndrome and request for left carpal tunnel release. Overall, the documentation provided in the medical records for this review is lacking with respect to clearly defining carpal tunnel syndrome for the left side that would benefit from surgical release. She has some documented signs and symptoms consistent with carpal tunnel syndrome, including paresthesias of both hands, symptoms that awaken her at night and has used splinting without resolution. However, a detailed sensory exam of the left hand is lacking to demonstrate specific median nerve compromise at the wrist. Phalen's and Tinel's signs are documented for the right side, but not for the left side. In addition, the patient has other complicating factors that make the diagnosis of carpal tunnel syndrome more difficult. Specifically, she is documented to have "cervical spine disc protrusion at C5-7 with neural foraminal stenosis and bilateral upper extremity radiculitis." This could suggest a double crush syndrome. As stated from ACOEM (Forearm, wrist and hand

complaints) page 270, Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Further from Campbell's Operative Orthopaedics, Twelfth Edition, 'Carpal tunnel syndrome (CTS) should not be confused with nerve compression caused by a cervical disc herniation or thoracic outlet structures or with median nerve compression proximally in the forearm and at the elbow.' Finally, relatively recent electrodiagnostic studies supporting carpal tunnel syndrome were not contained in the medical records provided for review. A report of electrodiagnostic studies from 7/2/12 does not diagnose carpal tunnel syndrome from either side. Electromyogram (EMG) studies are stated as normal. As stated from ACOEM (Forearm, wrist and hand complaints) page 270, "CTS must be proved positive by findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken." In summary, carpal tunnel syndrome on the left side has not been definitively diagnosed by history and clinical examination nor supported by electrodiagnostic studies. Thus, left carpal tunnel release in this patient based on the medical records reviewed cannot be considered medically necessary.