

Case Number:	CM14-0196209		
Date Assigned:	12/04/2014	Date of Injury:	01/31/2014
Decision Date:	01/28/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	11/24/2014

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, has a subspecialty in Reconstructive Surgery and is licensed to practice in Maryland. 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 37 year old female with a reported date of injury on 1/31/14 who requested left endoscopic carpal tunnel release. Documentation from 10/8/14 notes episodic numbness and shooting pains in the left middle finger and volar wrist. Examination of the left hand notes diminished sensation in the index and middle fingers with positive Phalen's and Durkan's test. Recommendation was made for splinting on the left and electrodiagnostic studies. The right thumb CMC joint was injected with steroid. Documentation from 11/5/14 notes electrodiagnostic studies revealed mild left carpal tunnel syndrome. She is on restricted duty at work and was instructed on splinting for the left wrist. Her left wrist is still bothering her with neuropathic pains. Her examination of the left hand and wrist has similar findings as from 10/8/14. Recommendation is for expanding her current physical therapy to the left carpal tunnel syndrome. She is going to continue current work restrictions and ask for authorization for left endoscopic carpal tunnel release. UR review dated 11/17/14 did not certify left endoscopic carpal tunnel release stating that the patient had not undergone conservative management of a steroid injection as recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left endoscopic carpal tunnel release: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 265 and 272.

Decision rationale: The patient is a 37 year old female with signs and symptoms of mild left carpal tunnel syndrome that is supported by electrodiagnostic studies. The patient is noted to have undergone splinting and has been on NSAIDs previously. On the last evaluation provided for review, the patient appears to have subjectively improved but with neuropathic pains of the left wrist. From ACOEM Chapter 11 page 260, CTS does not produce hand or wrist pain. In addition, the patient has not been documented to have undergone a steroid injection as recommended (or provided justification for not performing one). From ACOEM Chapter 11 page 272, Table 11-7, the following is recommended: injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after trial of splinting and medication (C). From page 265, CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. Finally, the patient was recommended to expand her physical therapy treatment to the left carpal tunnel. There has not been a follow-up examination to determine if there was any improvement/resolution in the patient's condition. In summary, given that the patient has a mild condition, no documentation of a steroid injection and that the patient has begun physical therapy for her left sided condition, left carpal tunnel release should not be considered medically necessary at this time.