

<b>Case Number:</b>	CM14-0204528		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	08/06/2013
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 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 38 year old male with a reported date of injury on 8/6/13 who requested bilateral carpal tunnel surgery and 1 box of Salopas. Initial evaluation dated 7/17/14 noted that the patient complains of bilateral hand pain, right greater than the left. Examination notes Tinel's and Phalen's signs positive at bilateral wrists. Assessment is that the patient has possible bilateral carpal tunnel syndrome. Bilateral wrist splints for nighttime use were recommended, as well as NSAIDs and topical analgesics. If the patient continues to have pain in his upper extremities, he will be a possible candidate for cortisone injection (s). Initial Orthopedic Panel Qualified Medical Evaluation dated 8/7/14 notes that the patient complains of intermittent numbness of both hands. He had previously undergone physical therapy for neck/back and shoulder complaints. Examination notes median nerve compression test was minimally positive on the right and negative on the left. Phalen's and Tinel's were negative at the wrists. Diagnoses did not list carpal tunnel syndrome. Progress report dated 8/28/14 notes that the patient still complains of numbness and tingling in both hands. He has been wearing his wrist braces at night. Examination notes tingling in the median nerve distribution bilaterally that is made worse with Phalen's and Tinel's. The patient has diffuse pain with handshake test. The patient is unable to tolerate anti-inflammatories. Continued conservative management versus bilateral carpal tunnel release was discussed with the patient. As the right side is a little more problematic, it would be performed first. The possibility of a steroid injection was discussed. However, the patient is a diabetic with constant numbness in his fingers and a moderate degree of carpal tunnel syndrome on electrodiagnostic studies. Therefore, I recommend surgery. Progress report dated 10/23/14 notes that the patient still complains of bilateral hand and wrist pain with paresthesias despite wearing bilateral wrist splints. His greatest orthopedic complaint is his lumbar spine. Stated report from electrodiagnostic studies dated 4/19/14 notes

moderate bilateral carpal tunnel syndrome UR dated 11/12/14 did not certify the surgeries and Salonpas stating that there has been very limited conservative treatment related to the hands. 'Since this patient has had no therapy for the wrists, and no injections, surgery is not medically necessary at this time.' With respect to Salonpas, based on the documentation provided, these pads have been used since July of 2014 without documented improvement; thus, they should not be considered medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Prospective request 1 carpal tunnel surgery, left hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 270. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome (Acute & Chronic)

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

**Decision rationale:** The patient is a 38 year old with signs and symptoms of possible bilateral carpal tunnel syndrome with stated electrodiagnostic studies showing a moderate condition. The patient is not documented to have evidence of severe condition and thus urgent surgical treatment is not indicated. The patient is noted to have undergone splinting and has been on non-steroidal anti-inflammatory drugs (NSAIDs) previously. He complains of hand and wrist pain. From ACOEM Chapter 11 page 260, carpal tunnel syndrome (CTS) does not produce hand or wrist pain. In addition, the patient has not been documented to have undergone a steroid injection as recommended. 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). On a previous evaluation, the surgeon noted that if the patient continued with upper extremity pain, he would be a candidate for a steroid injection. On a more recent evaluation, a steroid injection was discussed but was not recommended. 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. In summary, the patient has signs and symptoms of possible moderate carpal tunnel syndrome supported by electrodiagnostic studies. However, the patient has not undergone recommended treatment by ACOEM of a steroid injection after his trial of splinting and medication. Thus, carpal tunnel release surgery is not medically necessary.

**Prospective request 1 carpal tunnel surgery, right hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (Acute & Chronic)

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

**Decision rationale:** The patient is a 38 year old with signs and symptoms of possible bilateral carpal tunnel syndrome with stated electrodiagnostic studies showing a moderate condition. The patient is not documented to have evidence of severe condition and thus urgent surgical treatment is not indicated. The patient is noted to have undergone splinting and has been on non-steroidal anti-inflammatory drugs (NSAIDs) previously. He complains of hand and wrist pain. From ACOEM Chapter 11 page 260, carpal tunnel syndrome (CTS) does not produce hand or wrist pain. In addition, the patient has not been documented to have undergone a steroid injection as recommended. 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). On a previous evaluation, the surgeon noted that if the patient continued with upper extremity pain, he would be a candidate for a steroid injection. On a more recent evaluation, a steroid injection was discussed but was not recommended. 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. In summary, the patient has signs and symptoms of possible moderate carpal tunnel syndrome supported by electrodiagnostic studies. However, the patient has not undergone recommended treatment by ACOEM of a steroid injection after his trial of splinting and medication. Thus, carpal tunnel release surgery is not medically necessary.

**Prospective request 1 prescription of Salonpas patches, 1 box:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals Page(s): 105.

**Decision rationale:** The patient is a 38 year old male with ongoing pain of the bilateral hands and wrists, as well as the spine. He was initially prescribed Salonpas in July of 2014 for a diagnosis of bilateral lateral epicondylitis. Salonpas is a topical analgesic composed of menthol and methyl salicylate (type of NSAID). On the most recent evaluation, there was no documentation of a response to previous topical analgesics or reference to the patient's elbow complaints. The RFA appears to suggest that the treatment is for the spine; however, this is not clear and response to previous treatment had not been documented. Salicylate topicals are recommended as topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than

placebo in chronic pain. However, there has not been a documented response to this treatment. Therefore, this request is not medically necessary.