

Case Number:	CM14-0098752		
Date Assigned:	07/28/2014	Date of Injury:	02/13/2011
Decision Date:	01/02/2015	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/27/2014

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 Family Medicine, and is licensed to practice in 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 with a reported date of injury of 02/13/2011. The patient has the diagnoses of cervical spine protrusion at C5-C7 with neural foraminal stenosis, status post right shoulder surgery, left rotator cuff syndrome, bilateral upper extremity radiculitis, bilateral carpal tunnel syndrome and lumbar spine disc protrusion with bilateral lower extremity radiculitis. Per the requesting physician's progress reports dated 04/22/2014, the patient had complaints of neck pain rated a 7/0, right shoulder pain rated a 7/10, left shoulder pain rated a 6/10, right wrist pain rated a 7/10 and left wrist pain rated a 6/10 with low back pain rated a 7/10. The physical exam noted thenar atrophy in the wrist with decreased range of motion in the wrists, positive Tinel's and Phalen's sign on the right-hand decreased upper extremity reflexes. The treatment plan recommendations included cancellation of the right shoulder MRI, moving forward with a right carpal tunnel release followed by a left carpal tunnel release 6-8 weeks later.

IMR ISSUES, DECISIONS AND RATIONALES

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

LT Carpal Tunnel release: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM

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

Decision rationale: 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. 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. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression. Risks of surgical decompression include complications of anesthesia, wound infection, and damage to the median nerve. Incomplete decompression or recurrence of symptoms can lead to the need for further surgery. Based on the data from the randomized controlled trials, endoscopic carpal tunnel release seems to be an effective procedure compared to open surgery; however, greater emphasis must be given to training surgeons in this technique to avoid major complications such as median nerve injuries. With proper training and equipment, endoscopic carpal tunnel release can be done safely, with complication rates comparable to those for the open technique and with high patient satisfaction. Early return to work after either type carpal tunnel surgery is more dependent on the willingness of the employer and patient than on the surgical technique. Two prospective randomized studies show no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home therapy program. The provided documentation does not mention any neurologic deficits in the left hand. The Tinel's and Phalen's sign is mentioned to be positive on the right, but there is no mention on the left. There are also no included EMG/NCV studies that show carpal tunnel syndrome present in the left wrist. Therefore criteria per the ACOEM have not been met and the request is not medically necessary.