

Case Number:	CM15-0107188		
Date Assigned:	06/11/2015	Date of Injury:	05/16/2014
Decision Date:	07/17/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports Medicine

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 injured worker is a 32 year old female, who sustained an industrial injury on 05/16/2014; the mechanism of injury is documented as writing on a sticky note. According to a Comprehensive Follow Up Orthopedic Examination dated 05/05/2015, the injured worker was seen for a postoperative evaluation of her right hand and a follow up examination of the left hand. Present complaints included worsening of right and left wrist/hand pain since the last visit, worsening of weakness of wrist/hand and difficulty gripping objects and continued pain, numbness and tingling to the 1st, 2nd, 3rd and 4th digits of the right hand (worsening since last visit) as well as locking of the 5th digit (worse in the morning). Examination of the right wrist demonstrated mild tenderness over the volar aspect on the right. Phalen's sign, Tinel's sign and Carpal Compression test was positive on the right. Measurement of joint motion was decreased in the right and left wrist with flexion, extension, radial deviation and ulnar deviation. Muscle strength measurement was decreased in the right flexors, extensors, radial deviators and ulna deviators. Diagnoses included carpal tunnel syndrome and tenosynovitis of wrist. The treatment plan included carpal tunnel release of the left wrist as soon as possible, surgical assistant, postoperative physical therapy of the left wrist and continuation of physical therapy of the right wrist. Currently under review is the request for left carpal tunnel release at wrist, decompress forearm 1 space, decompression of ulnar nerve at wrist, decompression for carpal tunnel syndrome with surgical assistant and post-op physical/occupation therapy 3 x per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left carpal tunnel release at wrist, decompress forearm 1 space, decompression of ulnar nerve at wrist, decompression for CTS with surgical assistant: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), carpal tunnel syndrome chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-270. Decision based on Non-MTUS Citation Green's Operative Hand Surgery, 6th edition Pages 986-990.

Decision rationale: This is a request for multiple unsupported surgeries. Records reviewed indicate right upper extremity electro diagnostic testing and MRI were normal and subsequent repeat bilateral electro diagnostic testing on February 26, 2015 was minimally abnormal with the distal median motor onset latency falling well within accepted normal limits on both sides (2.3 ms on the left and 1.8 ms on the right) and mild slowing of long segment median sensory peak latency. The California MTUS notes that individuals with milder electro diagnostic abnormalities have the "poorest post surgery results" (page to 70). In such equivocal cases, studies have shown improvement following carpal tunnel corticosteroid injection correlate with post-operative pain relief; it is unclear from records provided whether such injection was performed. Therefore, the requested carpal tunnel release surgery is poorly supported. Surgical technique is beyond the scope of the California MTUS, but described in detail in the specialty text referenced which notes, "synovectomy is not indicated during primary carpal tunnel decompression" (page 990). There is no indication for the requested ulnar nerve decompression surgery. Decompressive fasciotomy is performed for acute compartment syndrome which is absent in this case and unnecessary. Carpal tunnel release even when performed with a larger traditional open technique is a small surgery performed through a 2-3 cm incision a surgical assistant is not necessary. Therefore, radical synovectomy is unnecessary, ulnar nerve decompression is unnecessary, decompressive fasciotomy is unnecessary and a surgical assistant is unnecessary and the combined request is determined to be medically unnecessary.

Post-op physical/occupational therapy 3x per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel syndrome chapter.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: The California MTUS notes that, there is limited evidence demonstrating effectiveness of therapy for carpal tunnel syndrome and, carpal tunnel release surgery is a relatively simple operation that should not require extensive therapy visits for recovery (page

15). The guidelines support 3-8 therapy sessions over 3-5 weeks after carpal tunnel release surgery (page 16). An initial course of therapy is defined as one half the maximal number of visits (page 10) 4 sessions following carpal tunnel surgery. Additional therapy sessions up to the maximum allowed is appropriate only if there is documented functional improvement defined as clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment (page 1). The requested 12 sessions exceeds guidelines and is not medically necessary.