Case Number:	CM15-0163700		
Date Assigned:	09/14/2015	**Date of Injury:**	09/08/2014
Decision Date:	10/13/2015	**UR Denial Date:**	07/21/2015
Priority:	Standard	**Application Received:**	08/19/2015

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: Maryland, Virginia, North Carolina
Certification(s)/Specialty: Plastic Surgery

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 9-8-14. Medical record indicated the injured worker is undergoing treatment for bilateral hand carpal tunnel syndrome and mild medial epicondylitis. Treatment to date has included bilateral wrist braces, cortisone injections, and oral medications including Motrin and activity modifications. On 6-25-15 the injured worker complains of pain into her bilateral arms and the volar aspect of the wrist and digits and on 7-16-15, the injured worker complains of numbness and tingling in hands with pain to her bilateral medial elbows. Physical exam on 6-25-25 and on 7-16-15 revealed full and symmetric range of motion of bilateral upper extremities; continued tenderness to palpation of bilateral medial epicondyles with mild pain elicited upon resisted pronation of the forearms. The treatment plan included a re-request for surgical intervention to include bilateral carpal tunnel releases right followed with left. On 6-1-15 a request for authorization was submitted for bilateral carpal tunnel release and post-op occupational therapy and post op-medications including Keflex and Vicodin. On 7-21-15, utilization review non-certified a request for bilateral carpal tunnel release, right side then left noting criteria have not been met per the guidelines and denied a request for post-op physical therapy noting the medical necessity of the procedure was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Carpal Tunnel Release, right side and then left: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation 1. Indications for Performing Carpal Tunnel Surgery: Clinical Quality Measures. Maggard, Melinda A.; Harness, Neil G.; Chang, Walter T.; Parikh, Janak A.; Asch, Steven M.; Nuckols, Teryl K.; Plastic & Reconstructive Surgery. 126(1): 169-179, July 2010. 2. Nerve Entrapment: Update. Tang, David T.; Barbour, John R.; Davidge, Kristen M.; Yee, Andrew; Mackinnon, Susan E. Plastic & Reconstructive Surgery. 135(1): 199e-215e, January 2015.

Decision rationale: The patient is a 32 year old female with signs and symptoms of possible bilateral carpal tunnel syndrome that has been treated conservatively with therapy, splinting, medical management and has had a positive response from steroid injections bilaterally. She is noted to have worsening function and progression of her symptoms. However, the diagnosis is not supported by electrodiagnostic studies, as they have been reported as normal. Previous UR had noted that the patient had not undergone a comprehensive conservative trial for her bilateral carpal tunnel syndrome. However, based on the medical records provided for this review, this had been performed. In addition, the diagnosis had been confirmed with positive responses to steroid injections bilaterally. Generally, positive electrical studies are required prior to certification for surgery as outlined below: '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 are very rare.' However, as stated, there are rare conditions when moderate or severe CTS have normal EDS. This may be one of those cases. The patient has clinically diagnosed bilateral carpal tunnel syndrome that has failed extensive conservative management. This has included bilateral steroid injections, which helped to confirm the clinical diagnosis. From the 1st reference: 'For patients with mild or moderate symptoms, a lack of electrodiagnostic confirmation makes surgery inappropriate unless the presentation reflects a high probability of carpal tunnel syndrome and an attempt at conservative therapy has failed (thereby allowing patients with false-negative tests to undergo surgery).' In addition, from the second reference, 'Electrodiagnostic studies are conventionally used to diagnose compression neuropathies but should be considered more of a confirmatory/adjunctive modality, or a means of excluding other abnormality. In fact, some authors support the surgical management of compression neuropathies without electrodiagnostic studies, with demonstration of good outcomes in patients foregoing this diagnostic tool.' Thus, this is one of those rare cases and bilateral carpal tunnel release should be considered medically necessary. In addition, from Table 11-7, page 272, ACOEM specifically does not recommend frequent or repeat steroid injections to the carpal tunnel. Therefore, there is likely no further treatment that would improve or treat the patient's condition. The UR stated that the patient had had 2 previous electrodiagnostic studies that were normal and thus did not satisfy guidelines. However, as reasoned above, there can be cases of carpal tunnel syndrome that have electrodiagnostic studies that are normal. In this case, the overall clinical picture of worsening function despite extensive conservative management

provides sufficient justification for surgical intervention. In addition, the clinical diagnosis was confirmed with a positive response to steroid injection.

Post operative occupational therapy 3 times a week for bilateral wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, and Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

Decision rationale: As bilateral carpal tunnel release was considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines: From page 15 and 16, Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Carpal tunnel syndrome (ICD9 354.0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks. Postsurgical physical medicine treatment period: 3 months. Postsurgical treatment (open): 3-8 visits over 3-5 we. Postsurgical physical medicine treatment period: 3 months. From page 10, Initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. Therefore, based on these guidelines, 6 visits would exceed the initial course of therapy guidelines and should not be considered medically necessary. Up to 4 visits would be consistent with these guidelines.