

<b>Case Number:</b>	CM15-0169519		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	06/17/2014
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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 48 year old female, who sustained an industrial injury on 6-17-14. The diagnoses have included right carpal tunnel syndrome, history of right dorsal wrist ganglion cyst, right De Quervain's tenosynovitis, and status post excision of right volar wrist ganglion cyst on 3-25-15. Treatment to date has included long term anti-inflammatory medications, splinting, modified work duty, steroid injections to the carpal tunnel, occupational therapy and home therapy. Currently, as per the physician progress note dated 7-3-15, the injured worker complains of chronic symptoms diagnostic of carpal tunnel syndrome that had been present for more than 12 months. The diagnostic testing that was performed included electromyography (EMG) and nerve conduction velocity studies (NCV) of the bilateral upper extremities was within normal limits. The current medications included Voltaren, Protonix and Ultram. The objective findings-physical exam reveals focal tenderness present over the carpal tunnel, positive Tinel sign, positive Durkin sign and positive Phalen sign. The Katz hand diagram is consistent with moderate probability for carpal tunnel syndrome. The physician notes that despite the extent of conservative treatment, the injured worker continues to be symptomatic with the current level of symptoms precluding return to a full duty work status and many simple activities of daily living (ADL). The physician requested treatments included Right Carpal Tunnel Decompression, as outpatient, Associated Surgical Services: Norco 10-325 mg quantity of 40 with 0 refills, for post-operative use for Right Hand, as outpatient, Post-operative Occupational Therapy, Right Hand, 2 times weekly for 3 weeks, 6 sessions, as outpatient. Agreed medical examination dated 5/20/15 noted agreement with recommendation for right carpal tunnel release. However, the patient is noted to have evidence of a double-crush syndrome due to cervical spinal stenosis. Diagnostic impression from a previous radiographic study noted moderately severe central spinal

stenosis and severe bilateral foraminal stenosis. There is borderline cord compression. There is exiting bilateral C6 nerve impingement bilaterally. Documentation from 7/25/14 noted the patient underwent a steroid injection to the right carpal tunnel. Specific response to this injection was not documented.

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

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

#### **Right Carpal Tunnel Decompression, as outpatient: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Carpal Tunnel Syndrome, Carpal Tunnel Release Surgery.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. 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. 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 48-year-old female with signs and symptoms of a possible right carpal tunnel syndrome that is not supported by electrodiagnostic studies. However, she has failed extensive conservative management of activity modification, splinting, steroid injection and medical management over a period of approximately 12 months. In addition, her condition and surgical treatment is supported by AME. from May 2015. The patient continues to have positive exam findings of positive Tinel's and Phalen's test, abnormal Katx hand diagram, and decreased sensation in the median nerve, supported by the AME. 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 is very rare.' However, as stated, there are rare conditions when moderate or severe CTS has normal EDS. This may be one of those cases. The patient has clinically diagnosed right carpal tunnel syndrome that has failed extensive conservative management. 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 right carpal tunnel release should be considered medically necessary. Finally, to address the patient's possible double crush syndrome, from the second reference, 'In cases of multiple nerve compressions either of the same or different peripheral nerves, surgical decompression should be performed safely and logically. Surgeons and patients should carefully weigh the surgical risks

and benefits of each required decompression before proceeding to the operating room. In some instances, these procedures can be performed in a single operation (e.g., carpal tunnel release, Guyon canal release, and cubital tunnel surgery). In other instances, it is more prudent to stage these procedures. For example, in patients with evidence of both thoracic outlet syndrome and cubital tunnel syndrome, performing the distal cubital tunnel operation before the thoracic outlet syndrome decompression may provide sufficient relief of clinical symptoms without exposing the patient to the increased risk of the thoracic outlet syndrome surgery. It will also allow more adequate time to conservatively manage the thoracic outlet syndrome condition with physical therapy and other nonsurgical means.' Therefore, it may be prudent as well to address the carpal tunnel prior to any neck surgical intervention. In summary, although the patient has normal electrodiagnostic studies, there is sufficient subjective and objective findings supported by AME, to clearly diagnose a right carpal tunnel syndrome. She has failed extensive conservative management over an approximately 1-year period. Right carpal tunnel release should be considered medically necessary. The UR review stated that based on guideline recommendations, lack of subjective symptoms and objective findings, the procedure was not considered medically necessary. The patient was stated not to have any nocturnal symptoms; however, this is documented from 7/30/15. In addition, the patient has clear objective findings that is supported by AME. The lack of a positive EDS is reasoned above. The request is medically necessary.

**Associated Surgical Services: Norco 10/325 mg Qty 40 with 0 refills, for post-operative use for Right Hand, as outpatient: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

**Decision rationale:** As the procedure was considered medically necessary, acute postoperative pain control should be considered medically necessary. From page 3 of Chronic Pain Medical Treatment Guidelines, the following is stated: Most acute pain is self-limited and may respond to short term administration of analgesics and conservative therapies. The request is not medically necessary.

**Post operative Occupational Therapy, Right Hand, 2 times wkly for 3 wks, 6 sessions, as outpatient: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

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

**Decision rationale:** As the 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 weeks. 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. The request is medically necessary.