

Case Number:	CM15-0185931		
Date Assigned:	09/28/2015	Date of Injury:	03/12/2014
Decision Date:	11/10/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/21/2015

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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand 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 46 year old female who sustained an industrial injury on 03/12/2014. Medical records indicated the worker was treated for cervical spine sprain-strain, bilateral carpal tunnel syndromes, status post bilateral carpal tunnel releases, right shoulder pain, right elbow pain, bilateral upper extremity overuse tendinopathy, bilateral elbow epicondylitis, and elbow tendinitis. In the provider notes of 08-28-2015 the injured worker complains of numbness and bilateral wrist pain. She describes her bilateral hand and wrist pain as stabbing and aching. Her wrist pain is rated as a 7-8 on a scale of 0-10, and bilateral hand pain as an 8 on a scale of 0-10, and pain in the left arm is rated a 7 on a scale of 0-10. On examination, she has tenderness, a positive Tinel's at the left wrist radiating into the forearm, positive Phalen's bilaterally, a positive left Finkelstein, decreased grip strength, decreased sensation in the median nerve bilaterally, decreased fingertip sensation on the left hand, and decreased range of motion on the right. The worker is currently working and not attending any therapy. A request for authorization was submitted for; 1. Bilateral Carpal Tunnel Release; 2. Associated Surgical Service: Preoperative Clearance; 3. Associated Surgical Service: Post-operative physical therapy, twice a week for four weeks for bilateral wrists; 4. Associated surgical service: VQ OrthoStim and supplies, batteries. A utilization review decision 08/26/2015 non-certified each of the requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Carpal Tunnel Release: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The carpal tunnel release is not medically necessary. According to the ACOEM guidelines, Chapter 11, page 270, "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." This patient has already had carpal tunnel releases. A 2012 NCV showed recurrent carpal tunnel syndrome, but a repeat study in 2014 was normal. The surgeon indicated in his October 2015 note a plan to repeat the nerve study. The records do not confirm the diagnosis of carpal tunnel syndrome by nerve testing. The ACOEM guidelines are not met. The request is not medically necessary.

Associated Surgical Service: Preoperative Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Low Back updated 5/15/15.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Post operative physical therapy, twice a week for four weeks for bilateral wrists: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated surgical service: VQ Orthostim and supplies, batteries: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.