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| <b>Case Number:</b>   | CM15-0205911 |                              |            |
| <b>Date Assigned:</b> | 10/22/2015   | <b>Date of Injury:</b>       | 02/27/2012 |
| <b>Decision Date:</b> | 12/03/2015   | <b>UR Denial Date:</b>       | 09/21/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/20/2015 |

### 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 56 -year-old female who sustained an industrial injury on 2-27-2012 and has been treated for right hand and wrist pain and numbness, and she is status post repeat left carpal tunnel decompression performed 6-30-2015. The pre-operative history and physical states that the injured worker underwent an initial left carpal tunnel release 10-15-2013, and a right release on 8-21-2013, then she experienced recurrent bilateral carpal tunnel symptoms including pain and paresthesias in her wrists and hands. Electromyography and nerve conduction studies dated 1-30-2015 had shown "nerve conduction slowing across both wrists." Examination had shown numbness and tingling to both hands including long and index fingers, positive Tinel's sign over the left carpal tunnel, and left-sided 1st dorsal interosseous muscle atrophy. A repeat left carpal tunnel decompression was performed 6-30-2013. Since the surgery she has been treated with use of a splint and medication. On 9-3-2015 the physician progress note states that the left wrist "would do better with physical therapy." Additionally, it states that based on the previous electromyogram, "she has the same problem of recurrent carpal tunnel syndrome on the right." A request was submitted for right-sided carpal tunnel surgery with related services, and 12 weeks of post-operative physical therapy for the left wrist. All were denied on 9-21-2015. Documentation from 6/30/15 noted a negative Tinel's sign of the right wrist. More recent documentation noted a positive Tinel's sign of the right wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Carpal Tunnel Release Right: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The patient is a 56 year old female with a history of diabetes who has signs and symptoms of a possible recurrent right carpal tunnel syndrome. This is supported by previous electrodiagnostic studies. However, a clear recent trial of conservative management has not been adequately documented. It is unclear if the patient has undergone recent splinting, and or consideration for a steroid injection to help facilitate the diagnosis, especially considering the history of diabetes and previous right carpal tunnel release. From page 270, ACOEM, Chapter 11, 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. Further from page 272, Table 11-7, injection of corticosteroids into to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, without clear documentation of a recent comprehensive trial of conservative treatment including splinting and consideration for a steroid injection, right carpal tunnel release should not be considered medically necessary.

**Surgical Clearance: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Physical Therapy 2x6 Left Wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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