

<b>Case Number:</b>	CM15-0213989		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	09/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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 41 year old male who sustained an industrial injury on July 24, 2013. Medical records indicated that the injured worker was treated for left wrist pain. His medical diagnoses include left carpal tunnel syndrome, left elbow medial and lateral epicondylitis and left upper ulnar limb lesion. In the provider notes dated October 19, 2015 to October 28, 2015 the injured worker complained of bilateral wrist and left elbow pain with numbness and tingling. He has doing physical therapy, using H wave machine at home and wearing wrist braces. He states his pain has progressed. He has pain with rest, his pain is aggravated with computer work, and he has limited lifting and carrying using his left arm. His right wrist is starting to hurt. The H wave causes numbness and his pain returns when H wave not in use. When he rests his left elbow on armrest, he has pain radiating from medial elbow down to his left wrist. He takes Tylenol #3 for pain. On exam, the documentation stated that there was a positive median nerve compression test and a positive cubital tunnel test for ulnar neuropathy. There was no thenar or hypothenar atrophy. There is decreased grip strength. The treatment plan is physical therapy and rehabilitative program. A Request for Authorization was submitted for surgery left endoscopic carpal tunnel release left wrist. The Utilization Review dated September 30, 2015 denied the request for surgery left endoscopic carpal tunnel release left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Surgery Left Endoscopic Carpal Tunnel Release, Left Wrist: Overturned**

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

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

**Decision rationale:** The patient is a 41 year old male with signs and symptoms of a possible left carpal tunnel syndrome, including numbness, positive Phalen's and median nerve compression test. He has undergone conservative management of medical management, splinting, physical therapy, activity modification and a steroid injection to the left carpal tunnel on 6/10/15. Electrodiagnostic studies from May 21, 2015 are consistent with a mild carpal tunnel syndrome. 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. Based on the medical documentation provided and the guidelines above, the patient has evidence of left carpal tunnel syndrome that has failed recommended conservative management of analgesia, splinting, physical therapy and specific steroid injection. His diagnosis is supported by electrodiagnostic studies. Therefore, left carpal tunnel release should be considered medically necessary. The UR stated that there is a lack of documentation of a positive Katz diagram, a Flick test, nocturnal symptoms, and cortisone injection trials. Based on the medical documentation provided for this review, although the patient does not demonstrate specific signs/symptoms listed, there is sufficient documentation of a clinical diagnosis of left carpal tunnel syndrome as outlined by ACOEM guidelines and the patient is specifically noted to have failed a steroid injection.