

Case Number:	CM15-0222823		
Date Assigned:	11/18/2015	Date of Injury:	11/21/2013
Decision Date:	12/30/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/12/2015

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 33 year old female with an industrial injury date of 11-21-2013. Medical record review indicates she is being treated for lesion of ulnar nerve of right upper limb, lateral epicondylitis of right elbow, and carpal tunnel syndrome of right upper limb, contusion of knee and bursitis of right shoulder. Subjective complaints (10-16-2015) included "intractable" hand pain due to work injury. The pain is described as pins and needles. Severity of symptoms was described as "mild to moderate." "Carpal tunnel injection helped for 2 days allowing for 75-80% pain relief followed by a recurrence of symptoms." Work status (10-16-2015) is documented as modified duties. Current medications included Prilosec, Tramadol, Ambien CR, Xanax Adderall Diclofenac and Celexa. Prior treatment included occupational therapy, injections, braces, splints and medications. Prior diagnostics are documented by the treating physician in the 10-16-2015 note as follows: 02-16-2015 - "Slightly increased signal of the ulnar nerve at the level of the medial epicondyle, a finding that is non-specific and may be seen in asymptomatic individuals. No other overwhelming evidence to suggest ulnar neuropathy. " Electromyography and nerve conduction studies (05-02-2014) - "There is no evidence of a right ulnar neuropathy. There is no evidence of a right median neuropathy. There is no evidence of a right cervical 5-thoracic 1 radiculopathy." Physical exam (10-16-2015) noted no overt swelling or discolorations of the right wrist and hand. Range of motion was documented as full with stiffness and pain. Pulses were documented as normal with good capillary refill. Tinel, Phalen and carpal tunnel compression test were positive. Coordination is documented as good fine motor control, good intrinsic muscle function and good extrinsic function. On 11-02-2015 the request for 1 right endoscopic versus open carpal tunnel release and 12 post-operative occupational therapy visits was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right endoscopic versus open carpal tunnel release: Overturned

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations, 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 33 year old female with signs and symptoms of a right carpal tunnel syndrome that has failed conservative management of splinting, medical management, and activity modification. Her signs have included a positive Phalen's, Tinel's and Durkan's test. Previous electrodiagnostic studies did not show evidence of a right carpal tunnel syndrome. However, the patient is noted to have had a recent positive response from a steroid injection to the right carpal tunnel. Based on the entirety of the medical documentation, the patient has electrically negative right carpal tunnel syndrome that has failed appropriate conservative management. 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 appropriate conservative management. This has included a confirmatory injection into the right carpal tunnel, which has 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 right 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 had stated that the patient did not have

confirmatory electrodiagnostic studies. 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 right carpal tunnel syndrome despite recommended conservative management provides sufficient justification for surgical intervention. In addition, the clinical diagnosis was confirmed with a positive response to a carpal tunnel injection. The request is medically necessary.

12 post operative occupational therapy visits: 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 right carpal tunnel release was considered medically necessary, the following are relevant guidelines: From page 15 and 16, 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. Post-surgical 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, 12 visits would exceed the initial course of therapy guidelines and are not medically necessary. Up to 4 visits would be consistent with these guidelines.