

Case Number:	CM15-0051243		
Date Assigned:	03/24/2015	Date of Injury:	11/20/2012
Decision Date:	05/05/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/18/2015

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 (IW) is a 55-year-old male who sustained an industrial injury on 11/20/2012. Diagnoses include left radial neuropathy, status post left elbow arthrotomy and extension contracture release and left carpal tunnel syndrome. Treatment to date has included medications, physical and occupational therapy and bracing. Diagnostics performed to date included electrodiagnostic testing and MRIs. According to the progress notes dated 1/16/15, the IW reported pain and stiffness in the left elbow and occasional numbness and tingling in the fingers. A physical examination showed positive Tinels' sign over the carpal tunnel and no evidence of intrinsic or thenar weakness or atrophy. A request was made for left endoscopic vs open carpal tunnel release under local anesthesia with sedation on an outpatient basis to be done [REDACTED]; pre-op medical clearance at SCOI; and occupational therapy twice weekly for six weeks. Surgery was recommended for the left carpal tunnel syndrome. Rationale for non-certification was as follows: Although the electromyography does note mild left carpal tunnel syndrome and positive Tinel's sign, there is no documentation provided to support the additional guideline criteria required. The patient is noted to complain of occasional numbness and tingling in the fingers. Examination has noted positive Tinel's and negative Phalen's. There is no evidence of intrinsic or thenar atrophy. Conservative management has included medications, physical therapy, activity modification, home exercise program and bracing at night. Electrodiagnostic studies revealed a mild carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left endoscopy vs open carpal tunnel release under local anesthesia with sedation on an outpatient basis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: The patient is a 55 year old male with signs and symptoms of a possible mild left carpal tunnel syndrome. Overall, the symptoms of occasional numbness and tingling are consistent with a mild condition. The patient has undergone some conservative management as documented above. The mild condition is supported by the electrodiagnostic studies. Given these mild findings and without evidence of a severe condition (i.e. thenar atrophy), it is reasonable to consider a steroid injection to help to facilitate the diagnosis and complete the conservative management as recommended by ACOEM. From table 11-7, page 272; recommendations include an injection of corticosteroid into the carpal tunnel after trial of splinting and medications. From 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 postsurgery 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. Based on these recommendations and the overall mild nature of the symptoms and carpal tunnel syndrome, left carpal tunnel release should not be considered medically necessary.

Pre-operative medical clearance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: As the procedure was not considered medically necessary, pre-operative medical clearance should not be considered medically necessary.

Occupational therapy, twice weekly for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: As the procedure was not considered medically necessary, post-operative physical therapy should not be considered medically necessary.