

Case Number:	CM15-0086527		
Date Assigned:	05/08/2015	Date of Injury:	08/14/2012
Decision Date:	07/21/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/05/2015

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 59 year old female who sustained a work related injury August 14, 2012. Past history included diabetes and left shoulder arthroscopy, August 2014. According to a primary treating physician's report, dated March 5, 2015, the injured worker presented with increased low back, buttock, and lateral hip pain, with radiation down the lower extremity to the knee. There is increased right lower extremity pain with the right leg giving way. She has a poor sitting tolerance and finds the medication is reducing the pain by 40%. Diagnoses are cervical spondylosis; left shoulder impingement syndrome; left biceps tendinitis; left knee patellofemoral chondromalacia; left wrist carpal tunnel syndrome; lumbar degenerative disc disease; sacroiliitis. Treatment plan included physical therapy, sacroiliac injections, and discussion of bilateral greater trochanter injection. A special physician's report for carpal tunnel surgery, dated March 27, 2015, describes the injured worker followed exhaustive conservative care; chronic use of splinting, modified work and restriction with activities of daily living, long-term use of anti-inflammatory medication, multiple dexamethasone injections to the carpal tunnels and the left first dorsal compartment, occupational therapy, and an ongoing home therapy program. Diagnoses are bilateral carpal tunnel syndrome and left DeQuervain's tenosynovitis. At issue, is the request for right carpal tunnel release and staged bilateral carpal tunnel decompression. Electrodiagnostic studies (EDS) dated 3/8/14 noted evidence of a mild right carpal tunnel syndrome and normal left side. Documentation from 1/13/15 notes a plan to repeat electrodiagnostic studies given the previous normal left sided study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Staged Bilateral Carpal Tunnel Decompression with Left First Dorsal Compartment

Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261 and 270.

Decision rationale: The patient is a 59-year-old female with signs and symptoms of bilateral carpal tunnel syndrome and left DeQuervain's tenosynovitis that has failed conservative management of bracing, NSAIDs, multiple injections to both carpal tunnels and first dorsal compartment. Electrodiagnostic studies (EDS) from 3/8/14 support a right carpal tunnel syndrome but normal left side. There had been documentation of a request for repeat EDS in January of 2015, but the status of this request and results from this study are neither clear nor documented. 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.' From page 261, 'Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist.' Based on these guidelines, left carpal tunnel release should not be considered medically necessary as previous EDS had documented normal findings on the left median nerve at the wrist. As is recommended and as stated from the physician evaluation dated 1/13/15, EDS can be repeated. If these studies continue to be normal for median nerve compression at the wrist and considering examination findings of left carpal tunnel syndrome with failure of appropriate conservative management, consideration could be given for carpal tunnel release in the setting of negative EDS studies. As documented in the UR, right carpal tunnel release and left 1st dorsal compartment release should be considered medically necessary. However, in this review, all three procedures have to be considered together, and thus should not be considered medically necessary, as a left carpal tunnel release is not considered medically necessary. If authorization for left-sided EDS had been denied, then consideration for left carpal tunnel release should be given without further study.