

Case Number:	CM13-0032066		
Date Assigned:	12/04/2013	Date of Injury:	04/08/2012
Decision Date:	01/29/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery; Hand Surgery, and is licensed to practice in Georgia and Texas. 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 physician 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/services. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This claimant is a 65-year-old female with a reported date of injury of 09/12/2011 to 09/12/2012. She was seen on 06/17/2013. She was tender over the flexor tendons at the right wrist but had full range of motion and there is no instability noted. There was no swelling noted. On 07/17/2013, she returned to clinic and at that time she had pain with some numbness and tingling to her right hand. Tinel's sign and Phalen's test were positive and she had numbness in the distribution of the median and ulnar nerve at that time. She was recommended for night splinting to her bilateral wrists at that time as well as a home exercise program with stretching and core strengthening. Electrodiagnostic study dated 08/21/2013, revealed entrapment neuropathy of the median nerves at both wrists with mild to moderate slowing of the nerve conduction velocity indicative of carpal tunnel syndrome. On 08/28/2013, she was again seen and the electrodiagnostic studies were reviewed. She had numbness in the distribution in the area of the median and ulnar nerve on the right wrist, had a positive Tinel's sign and Phalen's sign to the right wrist and had tenderness to the carpal tunnel. Surgery in the form of carpal tunnel release was recommended at that time due to failure of conservative measures. Diagnoses include musculoligamentous strain of the cervical spine, degenerative disc disease at C4-5, status post arthroscopic surgery of the left shoulder with residuals, impingement syndrome of the right shoulder, medial and lateral epicondylitis of the bilateral elbows and carpal tunnel syndrome of the bilateral wrists. Plan going forward was a right carpal tunnel release. ç

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release: 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): 270-271.

Decision rationale: Risks of surgical decompression include complications of anesthesia, wound infection, and damage to the median nerve. Incomplete decompression or recurrence of symptoms can lead to the need for further surgery. Based on the data from the randomized controlled trials, endoscopic carpal tunnel release seems to be an effective procedure compared to open surgery; however, greater emphasis must be given to training surgeons in this technique to avoid major complications such as median nerve injuries. With proper training and equipment, endoscopic carpal tunnel release can be done safely, with complication rates comparable to those for the open technique and with high patient satisfaction. Early return to work after either type carpal tunnel surgery is more dependent on the willingness of the employer and patient than on the surgical technique. Two prospective randomized studies show no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home therapy program. The medical records do indicate this employee has electrodiagnostic evidence of carpal tunnel syndrome to the bilateral wrists. The records do indicate that a night splint had been recommended. The record does not indicate that there is evidence of thenar atrophy indicative of severe carpal tunnel syndrome. Additionally, records are silent after 10/10/2013. Therefore, the current status of this employee is unknown and it is unknown whether the employee continues to have symptoms of carpal tunnel syndrome or whether her condition has improved. The records also do not indicate that the employee has failed to respond to all conservative measures as an injection has not been documented. At this time, the medical necessity of this procedure has not been documented by the records, and this request is non-certified.