

<b>Case Number:</b>	CM14-0164418		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	06/10/2011
<b>Decision Date:</b>	11/17/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/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 63-year-old male office administrator sustained an industrial injury on 6/10/11, relative to a fall. Past surgical history was positive for bilateral elbow surgery in 1976, and L4/5 anterior lumbar fusion on 5/8/13. Past medical history was positive for diabetes, hypertension, and asthma. The 10/24/13 electrodiagnostic study documented evidence of mixed motor and sensory distal peripheral neuropathy in the upper extremities. There was severe entrapment neuropathy of the median nerves at both wrists involving both myelin and axonal degeneration, superimposed on distal peripheral neuropathy. There was ulnar entrapment neuropathy across the right elbow with mild slowing of the nerve conduction velocities associated with distal peripheral neuropathy. The patient underwent left carpal tunnel release on 1/16/14 and right carpal tunnel release on 2/26/14. The 8/5/14 treating physician report cited pain and pulling sensation in the left palm when attempting to extend digits. There was intermittent locking of the right ring and bilateral small fingers. Physical exam documented well healed scar right palm with mild depression but no gross tethering with finger extension. There was a mild click with active extension of the right and small fingers. Left palm scar was thickened and depressed with visible tethering with active finger extension. There was pain to palpation of the flexor sheath of the left thumb at the metocarpophalangeal joint level and with passive extension. There was an extensor lag of the left thumb interphalangeal joint of approximately 30 degrees. There was positive left compression test and negative Tinel's and Phalen's tests. The diagnosis was left palmar flexor tendon adhesions, left thumb tenosynovitis, and right ring and little digit flexor tenosynovitis. The patient had resolution of compression neuropathy but had adhesions between surgical scar and flexor tendons which had been recalcitrant to therapy and corticosteroid injection. He developed a secondary contracture of the thumb and was at risk to develop similar symptoms in other digits without intervention. The treatment plan recommended revision of the median

neurolysis left palm with flexor tenolysis and hypothenar flap to provide barrier over tendons, A-1 pulley release left thumb, and corticosteroid injections for the right ring and little digit flexor sheaths. The 9/4/14 treating physician report documented the right 5th and left 4th fingers locked and the left thumb had burning pain and snapping. There was difficulty with left hand grasping. There was slight improvement in middle finger range of motion and 50% improvement with occasional locking. The left hand woke the patient at night due to pain and numbness. Physical therapy documented right grip strength 30/28/25 kg and left 10/6/6 kg. The diagnoses included bilateral carpal tunnel syndrome. Authorization was requested for bilateral carpal tunnel release. The 9/12/14 utilization review denied the request for bilateral carpal tunnel release as clinical exam findings did not meet guideline criteria, and there was no evidence of recent guideline-recommended conservative treatment or recent electrodiagnostic testing.

### **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:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2013, Carpal Tunnel Syndrome, Carpal Tunnel Release (CTR)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel syndrome, Carpal tunnel release surgery (CTR)

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. The Official Disability Guidelines provide clinical indications for carpal tunnel release that include specific symptoms (abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick Sign), physical exam findings (compression test, monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, and/or mild thenar weakness), conservative treatment (activity modification, night wrist splint, non-prescription analgesia, home exercise training), successful corticosteroid injection trial, and positive electrodiagnostic testing. Guideline criteria have not been met. There is no evidence of nocturnal symptoms relative to the right hand, or positive physical exam findings consistent with guideline criteria. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including splinting, and failure has not been submitted. There is no current electrodiagnostic evidence to support the diagnosis of carpal tunnel syndrome. Therefore, this request is not medically necessary.

#### **Left Carpal Tunnel Release: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2013, Carpal Tunnel Syndrome, Carpal Tunnel Release (CTR)

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

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. The Official Disability Guidelines provide clinical indications for carpal tunnel release that include specific symptoms (abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick Sign), physical exam findings (compression test, monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, and/or mild thenar weakness), conservative treatment (activity modification, night wrist splint, non-prescription analgesia, home exercise training), successful corticosteroid injection trial, and positive electrodiagnostic testing. Guideline criteria have not been met. There are limited physical exam findings consistent with guideline criteria. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including splinting, and failure has not been submitted. There is no current electrodiagnostic evidence to support the diagnosis of carpal tunnel syndrome. Therefore, this request is not medically necessary.