

Case Number:	CM14-0203789		
Date Assigned:	12/12/2014	Date of Injury:	04/30/2014
Decision Date:	02/11/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/05/2014

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 Minnesota. 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:

The injured worker is a 52-year-old female with a reported date of injury of 4/30/2013. The mechanism of injury was repetitive motion trauma. There is a history of bilateral carpal tunnel releases, the right carpal tunnel release on 5/4/2009 and the left on 6/29/2009. She complains of bilateral wrist pain and right elbow pain. She continues to experience paresthesias in the first second and third digits of both hands. Electrodiagnostic studies performed on 9/18/2014 revealed normal motor conduction of both median nerves. However, the sensory component revealed a focal neuropathic process involving bilateral median nerves at or near the wrist. There was an abnormal CSI bilaterally. (Normal is greater than 0.9 ms) There was no evidence of acute axonal loss. When compared to the prior study in 2008 there was an improvement of bilateral median motor distal latencies. However, in combination with the history and physical examination the findings were consistent with bilateral carpal tunnel syndrome. Clinical findings on August 12, 2014 included the painful right elbow. (Right) There was tenderness at the medial epicondyle. Tinel's was negative at the carpal tunnel, and ulnar nerve at the Guyon's canal. Phalen's was negative. (Left) no tenderness. Tinel's was negative at the carpal tunnel and Phalen's was also negative. Sensation was intact in all dermatomes of the hand and arm bilaterally. Utilization review noncertified a request for bilateral carpal tunnel releases because of absence of conservative treatment with carpal tunnel injections and splinting. Residual nerve conduction abnormalities may be present after carpal tunnel releases for several years. The motor median latencies were normal bilaterally and actually improved after the carpal tunnel releases. Provocative testing for the carpal tunnel syndrome including Tinel's and Phalen's were not always present. In light of the above, a repeat carpal tunnel release procedure was noncertified. This has been appealed to independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 261, 264, 270.

Decision rationale: California MTUS guidelines indicate symptoms of pain, numbness and tingling in the hands are common in the general population but based on studies only about 1 in 5 symptomatic subjects would be expected to have carpal tunnel syndrome based on clinical examination and electrophysiologic testing. The worker has had prior carpal tunnel releases bilaterally in 2009. The nerve conduction study shows improvement in the distal motor latencies of the median nerves compared to the preoperative study. Motor conduction is normal at this time. However, there is residual sensory carpal tunnel syndrome present. Residual prolongation of the sensory latencies is not uncommon after a carpal tunnel release. Documentation indicates inconsistencies in the testing for Tinel's sign and Phalen's sign which were not always positive. The guidelines suggest splinting of the wrist in neutral position at night and day and injection of lidocaine and corticosteroids into the carpal tunnel as a diagnostic and therapeutic test. The medical records provided do not include documentation of this type of conservative treatment. The risk of a repeat carpal tunnel release includes risk of damage to the median nerve from lysis of adhesions resulting from the previous surgery. Guidelines also state that patients with the mildest symptoms have the worst postoperative results. Based upon the documentation provided, the request for a right carpal tunnel release is not supported by guidelines and as such, the medical necessity of the request is not substantiated. Therefore, the request is not medically necessary.

Left carpal tunnel release surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 261, 264, 270.

Decision rationale: California MTUS guidelines indicate symptoms of pain, numbness and tingling in the hands are common in the general population but based on studies only about 1 in 5 symptomatic subjects would be expected to have carpal tunnel syndrome based on clinical examination and electrophysiologic testing. The worker has had prior carpal tunnel releases bilaterally in 2009. The nerve conduction study shows improvement in the distal motor latencies of the median nerves compared to the preoperative study. Motor conduction is normal at this time. However, there is residual sensory carpal tunnel syndrome present. Residual prolongation of the sensory latencies is not uncommon after a carpal tunnel release. Documentation indicates

inconsistencies in the testing for Tinel's sign and Phalen's sign which were not always positive. The guidelines suggest splinting of the wrist in neutral position at night and day and injection of lidocaine and corticosteroids into the carpal tunnel as a diagnostic and therapeutic test. The medical records provided do not include documentation of this type of conservative treatment. The risk of a repeat carpal tunnel release includes risk of damage to the median nerve from lysis of adhesions resulting from the previous surgery. Guidelines also state that patients with the mildest symptoms have the worst postoperative results. Based upon the documentation provided, the request for a left carpal tunnel release is not supported by guidelines and as such, the medical necessity of the request is not substantiated. Therefore, the request is not medically necessary.