Case Number:	CM14-0215163		
Date Assigned:	01/02/2015	**Date of Injury:**	08/19/2012
Decision Date:	02/20/2015	**UR Denial Date:**	12/02/2014
Priority:	Standard	**Application Received:**	12/23/2014

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. 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 patient is a 46 year old male with a date of injury on 7/3/12 who requested authorization for bilateral carpal tunnel surgery. He complains of chronic pain in his wrists and hands, as well as the neck. Symptoms include numbess, tingling and weakness that affects daily activities. Examination notes positive Phalen's and reverse Phalen's signs in both wrists with decreased grip strength. Two-point discrimination is 6 mm for both 2nd and 3rd fingers. Activity modification and work restrictions had been provided. His pain medications were addressed. Electrodiagnostic studies are stated to show bilateral moderate carpal tunnel syndrome. He is stated to have undergone extensive conservative management including medications, physical therapy,acupuncture and nighttime splinting. 'He wishes to avoid cortisone injections due to only partial and temporary benefit, and we respect his wishes.' Pain management notes findings of a possible cervical radiculopathy. UR review dated 12/1/14 did not certify bilateral carpal tunnel release stating that 'There is no documentation of failure of conservative management for either wrist(including bracing, medications, activity modification and cortisone injection) and no documentation of EMGs to confirm the reported diagnosis.'

IMR ISSUES, DECISIONS AND RATIONALES

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

Left wrist carpal tunnel release: 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): 265, 270 and 272.

Decision rationale: The patient is a 46 year old male with signs and symptoms of possible bilateral carpal tunnel syndrome that appears to have failed conservative management of splinting, medical management and activity modification. The patient has elected not to have steroid injections. However, the patient is only stated to have had electrodiagnostic studies that show moderate carpal tunnel syndrome. No actual report was provided for this review. The presence or absence of a cervical radiculopathy was not documented from the electrodiagnostic studies as well.From ACOEM, page 270, 'CTS [carpal tunnel syndrome] 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. Positive EDS in asymptomatic individuals is not CTS. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression.'Thus, based on these guidelines, left carpal tunnel surgery should not be considered medically necessary. The patient has only stated findings of moderate carpal tunnel syndrome. The actual report was not provided for review and is necessary to confirm the findings and to evaluate for possible cervical radiculopathy. Although ACOEM recommends steroid injection as part of the conservative management (from page 272, Table 11-7, the following is recommended: injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after trial of splinting and medication (C).), it is not an absolute requirement. On page 265, ACOEM states 'Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived.'In summary, the patient has evidence of possible bilateral carpal tunnel syndrome that has failed conservative measures. Steroid injection and response should not be considered an absolute requirement. However, there should be sufficient documentation of the electrodiagnostic report which is lacking in this case.

Right wrist carpal tunnel release: 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): 265, 270, 272.

Decision rationale: The patient is a 46 year old male with signs and symptoms of bilateral carpal tunnel syndrome that appears to have failed conservative management of splinting, medical management and activity modification. The patient has elected not to have steroid injections. However, the patient is only stated to have had electrodiagnostic studies that show

moderate carpal tunnel syndrome. No actual report was provided for this review. The presence or absence of a cervical radiculopathy was not documented from the electrodiagnostic studies.From ACOEM, page 270, '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. Positive EDS in asymptomatic individuals is not CTS. Studies have not shown portable nerve conduction devices to be effective diagnostic tools. Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome). Likewise, diabetic patients with peripheral neuropathy cannot expect full recovery and total abatement of symptoms after nerve decompression.'Thus, based on these guidelines, left carpal tunnel surgery should not be considered medically necessary. The patient has only stated findings of electrodiagnostic studies showing moderate carpal tunnel syndrome. The actual report is necessary for review to confirm the findings and to evaluate for possible cervical radiculopathy. Although ACOEM recommends steroid injection as part of the conservative management as on page 272, Table 11-7, (the following is recommended: injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS after trial of splinting and medication (C).), it is not an absolute requirement. On page 265, ACOEM states 'Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived.'In summary, the patient has evidence of possible bilateral carpal tunnel syndrome that has failed conservative measures. Steroid injection and response should be considered an absolute requirement. However, there should be sufficient documentation of the electrodiagnostic report, which is lacking in this case.