

<b>Case Number:</b>	CM15-0111945		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	02/01/2013
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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 53-year-old female, who sustained an industrial injury on 2/1/2013. She reported continuous trauma involving the shoulders and upper extremities. Diagnoses have included status post mini open rotator cuff repair April 2014 and bilateral carpal tunnel syndrome. Treatment to date has included bracing, cortisone injections and medication. According to the progress report dated 5/5/2015, the injured worker complained of ongoing wrist pain with numbness and tingling extending into the thumb, index finger and long finger. She reported that the pain awakened her at night and kept her from falling asleep. Her hands shook numerous times. Physical exam of the wrists and fingers was consistent with positive compression sign across the carpal canal on both sides. There was positive Tinel's sign to percussion over the median nerve in both wrists. Phalen's sign was positive in both wrists. The injured worker was temporarily totally disabled. Authorization was requested for bilateral carpal tunnel release and related services. Agreed medical examination (AME) dated 2/6/14 notes previous electrodiagnostic studies (EDS) that documented moderate bilateral carpal tunnel syndrome from April 25, 2013. In addition, there was no evidence of a cervical radiculopathy. The patient is noted to have a history of hypertension and diabetes mellitus. Documentation from 5/15/15 notes a progression of her bilateral carpal tunnel syndrome that has failed conservative care of bracing, NSAIDs, and anti-neuritics. She has had several cortisone injections to both wrists.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral carpal tunnel release: Overturned**

**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): 270 and 272.

**Decision rationale:** The patient is a 53-year-old female with signs and symptoms of probable progressive bilateral carpal tunnel syndrome. She has failed recommended conservative management of activity restriction, NSAIDs, splinting and previous cortisone injections. Her diagnosis is supported by electrodiagnostic studies from April of 2013. There was no evidence of cervical radiculopathy. 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 postsurgery 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." Further from page 272, Table 11-7, injection of corticosteroids into the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Thus, the patient has a clear diagnosis of bilateral carpal tunnel syndrome that has failed recommended conservative management and is supported by electrodiagnostic studies. Thus, bilateral carpal tunnel syndrome is medically necessary. UR review stated that EDS had not been provided. Based on the medical records provided for this review, this has been satisfied by the documentation within the AME on 2/6/14. Thus, the concern of the UR has been satisfied.

**Pre-op evaluation: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back pain, Preoperative testing, general.

**Decision rationale:** The patient is a 53-year-old female with a history of diabetes mellitus and hypertension. Bilateral carpal tunnel syndrome was considered medically necessary. From ODG guidelines and as general anesthesia is likely to be performed, preoperative testing should be as follows: An alternative to routine preoperative testing for the purposes of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. Thus, given the history of diabetes mellitus and hypertension, a preoperative evaluation is medically necessary, as it satisfies the recommended guidelines.

**Post op physical therapy; 12 sessions (2x6): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 15 16.

**Decision rationale:** As the bilateral carpal tunnel releases were considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines: From page 15 and 16, Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Carpal tunnel syndrome (ICD9 354. 0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks. Postsurgical physical medicine treatment period: 3 months. Postsurgical treatment (open): 3-8 visits over 3-5 weeks. Postsurgical physical medicine treatment period: 3 months. From page 10, "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d) (1) of this section. Therefore, based on these guidelines, 12 visits would exceed the initial course of therapy guidelines and should not be considered medically necessary. Up to 4 visits would be consistent with these guidelines.

**Associated surgical service: Wrist braces:** 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.

**Decision rationale:** Bilateral carpal tunnel releases were considered medically necessary. A request had been made for bilateral wrist splints. From ACOEM, Chapter 11, page 270, 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. Therefore, wrist splints after carpal tunnel surgery should not be considered medically, especially after 48 hours.

**Meds, pain, anti-inflammatroy, antineuritic for two (2) months (names, dose, and quantity not specified):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acute vs. Chronic pain model Page(s): 3.

**Decision rationale:** Bilateral carpal tunnel surgery was considered medically necessary. A request was made for meds, pain, anti-inflammatory, anti-neuritic for 2 months. As the specific medications, dosing and quantities were not detailed, they should not be considered medically necessary. From page 3, chronic pain treatment guidelines: Most acute pain is self-limited and may respond to short term administration of analgesics and conservative therapies. A 2 month supply would also not be consistent with guidelines for treatment of acute pain following surgery.