

Case Number:	CM15-0113119		
Date Assigned:	06/19/2015	Date of Injury:	01/14/2014
Decision Date:	07/28/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/11/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports Medicine

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 46 year old female who reported an industrial injury on 1/14/2014. Her diagnoses, and/or impressions, are noted to include: right carpal tunnel syndrome; De Quervain's Tenosynovitis, status-post left De Quervain's release (10/28/14); left upper extremity pain syndrome; right and left carpal tunnel syndrome, status-post injections (12/17/14); and ongoing neurologic symptoms in the bilateral upper extremities. A repeat nerve conduction velocity study was done on 5/11/2015, noted progression of right carpal tunnel syndrome; no current imaging studies are noted. Her treatments have included diagnostic studies; medication management; and modified work duties. The progress notes of 5/21/2015 reported pain and numbness I her hands, with constant numbness in the right hand, which is moderately benefited by bracing; she also reported positive Flicks sign; occasional sore and tight left hand, with use; radiating right hand pain/numbness into the finger tips; and that her right hand issues awaken her at night. Objective findings were noted to include positive Tinel's sign over the right carpal tunnel, and differentiation in the JAMAR Dynamometer testing between the right and left hands; otherwise negative and normal evaluations of the bilateral wrists/hands/arms are noted. The physician's requests for treatments were noted to include right carpal tunnel release surgery, and possible tenosynovectomy, with consultation for pre-operative clearance and a short arm splint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right endoscopic carpal tunnel release, possible tenosynovectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, table 11-7. Decision based on Non-MTUS Citation Official Disability Guidelines: Carpal Tunnel Syndrome chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Green's Operative Hand Surgery, 6th ed. Page 990.

Decision rationale: In this case, the request is for surgical treatment of carpal tunnel syndrome confirmed by electrodiagnostic testing with mild evidence of median neuropathy on September 22, 2014 testing and progression on repeat May 11, 2015 testing. There is evidence of appropriate non-surgical carpal tunnel treatment including splinting and injection which was temporarily helpful. The California MTUS would support consideration of carpal tunnel decompression surgery. However, there is no indication for synovectomy. Details of carpal tunnel surgical technique are beyond the scope of the California MTUS, but are described in detail in the specialty text referenced which notes on page 990 that, "synovectomy is not indicated during primary carpal tunnel decompression." Therefore, the combined request for carpal tunnel release and possible synovectomy is not supported as medically necessary.

Associated surgical service: Short Arm Splint: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 156. Decision based on Non-MTUS Citation Official Disability Guidelines: Carpal Tunnel Syndrome chapter.

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

Decision rationale: Records forwarded for review document that the patient was provided with a carpal tunnel night splint (March 19, 2015) and has been wearing a brace (April 23, 2015). This request is presumably for another post-operative splint. The California MTUS notes on page 270 that, "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 carpal tunnel release may be largely detrimental, especially compared to a home therapy program." There is no indication for another splint. Therefore, this request is not medically necessary.

Pre operative appointment, medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Testing before Noncardiac Surgery: Guidelines and Recommendations, Molly A. Feely, MD; C. Scott Collins, MD; Paul R. Daniels, MD; Esayas B. Kebede, MD; Aminah Jatoi, MD; and Karen F. Mauck, MD, MSc, Mayo Clinic, Rochester, Minnesota Am Fam Physician. 2013 Mar 15; 87(6):414-418.

Decision rationale: An extensive systematic review referenced above concluded that there was no evidence to support routine preoperative testing. More recent practice guidelines recommend testing in select patients guided by a perioperative risk assessment based on pertinent clinical history and examination findings, although this recommendation is based primarily on expert opinion or low-level evidence. In this case, there is no documented medical history to support the need for the requested evaluation; rather, records indicate the injured worker has undergone multiple surgical procedures without medical or anesthetic complications. Therefore, the request is determined to be not medically necessary.