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| Case Number: | CM15-0117216 | | |
| Date Assigned: | 06/25/2015 | Date of Injury: | 08/02/1995 |
| Decision Date: | 08/05/2015 | UR Denial Date: | 05/21/2015 |
| Priority: | Standard | Application Received: | 06/17/2015 |

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 63 year old male, who sustained an industrial injury on 8/2/1995. Diagnoses have included lumbar post-laminectomy syndrome, cervical spine stenosis and cervical radiculopathy. Treatment to date has included numerous discectomies and fusions, left cubital nerve decompression and carpal tunnel release (2004), night time splinting and medication. According to the progress report dated 5/6/2015, the injured worker returned after undergoing magnetic resonance imaging (MRI) of his elbow for operative planning. He complained of numbness and tingling in his ulnar ring finger and small finger that radiated from his shoulder and affected him all the time. He had associated weakness and clumsiness. He complained of pain over the medial epicondyle. Assessment for left carpal tunnel syndrome revealed positive median nerve compression and negative Tinel's. Phalen's test was positive. Authorization was requested for left carpal tunnel release with hypothenar fat flap coverage and post-op physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left carpal tunnel release with hypothenar fat flap coverage: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/16974219>.

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 63 year old male with signs and symptoms of possible recurrent left carpal tunnel syndrome that has failed conservative management of splinting and NSAIDs. There is no evidence of thenar atrophy to suggest a severe condition. In addition, previous EDS are not supportive of left carpal tunnel syndrome, but left cubital tunnel syndrome and C7 radiculopathy, Based on ACOEM guidelines, left carpal tunnel release should not be considered medically necessary. 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 post surgery 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 to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, as there are no supporting EDS and a corticosteroid injection to the carpal tunnel has not been considered to help facilitate the diagnosis (especially with negative EDS), left carpal tunnel release should not be considered medically necessary.

Post-operative physical therapy for the left wrist, 2 to 3 times a week for 4 to 6 weeks:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.