MAXIMUS Federal Services

Case Number:	CM15-0179215		
Date Assigned:	09/21/2015	Date of Injury:	05/06/2013
Decision Date:	11/02/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/11/2015

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 48 year old female, who sustained an industrial injury on May 6, 2013. She reported bilateral shoulder pain, worse on the left and neck pain. The injured worker was diagnosed as having neck pain, bilateral hand paresthesia with electrodiagnostic evidence of moderate to severe , right worse than left, carpal tunnel syndrome, bilateral elbow pain and lateral epicondylitis, worse on the left, mild cervical spondylosis, repetitive stress injury of the bilateral upper extremities and cervicalgia. Treatment to date has included diagnostic studies, "extensive" physical therapy, medications, left shoulder injection "not helpful", TENS unit "without much help", wrist braces and work restrictions. Currently, the injured worker continues to report bilateral elbow pain, bilateral shoulder pain and neck pain with associated numbness and tingling of the bilateral upper extremities that wakes her from sleep. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was without complete resolution of the pain. Evaluation on January 8, 2015, revealed continued pin as noted. She rated her pain at 8 n a 1-10 scale with 10 being the worst. Evaluation on April 16, 2015, revealed continued pain with associated symptoms as noted. She noted repetitive activities aggravated the symptoms. She noted increased pain even with modified duties. She reported wrist braces were helpful. She also reported occasional gastrointestinal upset. Phalen's and Tinel's tests were noted as positive. Home exercises, medications and braces were continued. An orthopedic surgeon was recommended. Evaluation on July 15, 2015, revealed continued pain as noted with tingling and numbness into the fingers. The RFA included requests for Bilateral endoscopic versus open carpal tunnel release and Post-op occupational therapy, bilateral wrists, 2

visits per week for 4 weeks and was non-certified on the utilization review (UR) on September 3, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral endoscopic versus open carpal tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Diagnoses and treatment of work related carpal tunnel syndrome, Washington State, Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: This is a request for bilateral carpal tunnel release surgery. Extensive records document that the majority of the patient's symptoms are not consistent with carpal tunnel syndrome, primarily neck and left greater than right shoulder pain. March 19, 2015 electrodiagnostic testing was just mildly abnormal with the distal median motor onset latency being 4.5 ms on the left and 4.6 ms on the right and sensory peak latency being 4.0 ms on the left and 4.4 ms on the right. Extensive treatment for diffuse symptoms with anti-inflammatory medications, muscle relaxants, narcotic pain medications, gabapentin, Lyrica, therapy, acupuncture, trigger point injections, left shoulder injection and use of a TENS unit is noted, but there is no documentation of treatment of carpal tunnel syndrome such as with night splinting of the wrists or carpal tunnel injection. The California MTUS notes that individuals with the mildest carpal tunnel syndrome have the worst results with surgery (page 270). Studies have shown good correlation between temporary improvement following carpal tunnel injection and subsequent relief of symptoms following carpal tunnel surgery. That is, if this individual with diffuse symptoms only a minority of which could be attributed to carpal tunnel syndrome did not have good temporary improvement following carpal tunnel injection, surgery is unlikely to be beneficial and not recommended. Bilateral carpal tunnel release is not medically necessary at this time.

Post-op occupational therapy, bilateral wrists, 2 visits per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

Decision rationale: The California MTUS notes that, "there is limited evidence demonstrating effectiveness" of therapy for carpal tunnel syndrome and, "carpal tunnel release surgery is a relatively simple operation" that should not require extensive therapy visits for recovery (page 15). The guidelines support 3-8 therapy sessions over 3-5 weeks after carpal tunnel release surgery (page 16). An initial course of therapy is defined as one-half the maximal number of visits (page 10), 4 sessions following carpal tunnel surgery. Additional therapy sessions up to

the maximum allowed is appropriate only if there is documented functional improvement defined as clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment (page 1). In this case, carpal tunnel surgery is not medically necessary at this time. If that later proves to be needed, the requested 8 post-op therapy sessions exceeds guidelines and is not needed.