

Case Number:	CM15-0073619		
Date Assigned:	04/23/2015	Date of Injury:	07/12/2013
Decision Date:	05/21/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/17/2015

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 62 year old female, who sustained an industrial injury on 07/12/2013. On provider visit dated 03/17/2015 the injured worker has reported worsening right carpal tunnel symptoms. On examination there was moderate swelling noted to the right volar and ulnar distal forearm and some intrinsic atrophy noted in right hand. Numbness and tingling were noted as well as burning pain at night. Nerve conduction study was consistent with recurrent bilateral carpal tunnel syndrome. The diagnoses have included carpal tunnel syndrome and ganglion of joint. Treatment to date has included previous surgical intervention, physical therapy, home exercise program and medication. The provider requested right redo carpal tunnel release with median nerve block, flexor synovectomy, median nerve neurolysis, hypothenar fat flap and right volar radial wrist ganglion excision. Conservative management has included splinting, NSAIDs, and physical therapy. She had previously undergone a steroid injection on July of 2014. Electrodiagnostic studies from 4/1/14 note a residual right severe carpal tunnel syndrome. She is noted to have worsening symptoms despite conservative management. The patient is noted to have a 2 cm volar ganglion cyst on examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right redo carpal tunnel release with median nerve block, flexor synovectomy, median nerve neurolysis, hypothenar fat flap and right volar radial wrist ganglion excision:
Overturned

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): s 270-272.

Decision rationale: The patient is a 62 year old female with signs and symptoms of a worsening recurrent right carpal tunnel syndrome, which is documented as severe on previous electrodiagnostic studies (EDS). She has failed conservative management of bracing, NSAIDs, steroid injection and physical therapy. She has findings of a severe nature with evidence of thenar/intrinsic atrophy. In addition, she has evidence of a ganglion cyst on examination. Given that she has evidence of a severe right carpal tunnel syndrome, consideration should be given for relatively early surgical intervention. From Chapter 11, page 270, Referral for hand surgery consultation may be indicated for patients who: - Have red flags of a serious nature- Fail to respond to conservative management, including worksite modifications- Have clear clinical and special study evidence of a lesion that has been shown to benefit, She has red flags of a serious nature with intrinsic atrophy and severe determination on EDS. Further, CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. From page 272, conservative management consists of steroid injection following failure of splinting and NSAIDs, for mild to moderate cases. However, the patient has a likely severe condition and therefore, the recommendation for a steroid injection does not appear indicated. However, she did undergo a previous steroid injection in July of 2014 with temporary relief. Therefore, right carpal tunnel release for this patient should be considered medically necessary. With respect to the ganglion cyst, as the carpal tunnel release is considered medically necessary and that the patient would likely undergo surgical intervention in the same regional area, it is prudent and medically necessary to resect the ganglion cyst in order to prevent a second operation and likely general anesthesia. From page 271, only symptomatic wrist ganglia merit excision, if aspiration fails. However, as stated the patient will likely need relatively early surgical intervention for the carpal tunnel syndrome and this supersedes the recommendation to wait for failure of an aspiration attempt. Therefore, the procedures of right carpal tunnel release and ganglion cyst resection should be considered medically necessary. The UR review states that conservative management for carpal tunnel syndrome was not documented and that the EMG studies were not provided for review. However, the nerve conduction velocities should be sufficient for determination and the patient is documented to have undergone conservative management including a steroid injection. As reasoned above, based on the severe nature of the carpal tunnel syndrome, this should be sufficient as well. Finally, the UR review states that an MRI is needed to confirm the diagnosis of ganglion cyst. This does not appear to be consistent with ACOEM recommendations. Therefore the request is medically necessary.