

Case Number:	CM15-0077622		
Date Assigned:	04/29/2015	Date of Injury:	12/17/2013
Decision Date:	06/08/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/23/2015

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 35-year-old female with a history of diabetes mellitus, with a reported date of injury of 12/17/2013. The diagnoses include bilateral moderate carpal tunnel syndrome. Treatments to date have included electrodiagnostic studies of the bilateral upper extremities showed moderate carpal tunnel syndrome and no signs of radiculopathy, anti-inflammatory medications, bracing, physical therapy, and acupuncture treatments. The progress report dated 03/17/2015 indicates that the injured worker developed pain and numbness in her hands. She rated the pain 5 out of 10. She felt dull pain in the hands or wrist up to her upper arms. The injured worker had limited activities of daily living due to pain and weakness. An examination of the bilateral hands and wrists showed no swelling, synovitis, or redness; tenderness to palpation more on the left than the right wrist; positive Phalen's test bilaterally; full range of motion of the fingers without restrictions; normal range of motion of the thumbs; normal range of motion of the wrist; and intact neurovascular status. The treating physician requested open end endoscopic left carpal tunnel release, pre-operative medical clearance, and post-operative physical therapy for the left wrist twice a week for four weeks. An examination of the bilateral wrists showed tenderness to palpation over the wrist, positive Tinel, normal sensation, ability to flex and extend the fingers without any difficulty, and soft and compressible forearm compartments. On 04/06/2015, Utilization Review (UR) denied the requests. The UR physician noted that there was no documentation of failure of conservative management for the wrist condition and no documentation of electromyography test to confirm the reported diagnosis. The MTUS/ACOEM Guidelines were cited. Electrodiagnostic studies (EDS) from 4/24/14 noted bilateral moderate

carpal tunnel syndrome with normal EMGs. Documentation from 4/7/15 noted worsening bilateral carpal tunnel syndrome. Tinel's was positive, while Phalen's and carpal compression was negative. There was no evidence of atrophy. The patient complained of nighttime symptoms. Conservative management has included bracing, medical management, activity modification, therapy and injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Open and Endoscopic Left Carpal Tunnel Release: 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): 270 and 272.

Decision rationale: The patient is a 35 year old female with worsening left carpal tunnel syndrome over a greater than 1 year period treated with well-documented conservative management including bracing, NSAIDs, activity modification, physical therapy and stated injection. Her signs and symptoms are consistent with a left carpal tunnel syndrome and her diagnosis is supported by EDS documenting moderate carpal tunnel syndrome. From page 270, ACOEM, 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. Based on these guidelines, left carpal tunnel release should be considered medically necessary for this patient. Even though, the patient is only stated to have failed injection, based on the entirety of the medical record, the diagnosis is not in question and steroids are only noted to provide temporary relief. The UR stated that conservative management had not been documented and that the EDS only documented a mild condition. This is not consistent with the medical records provided for this review, as the patient is well-documented to have undergone bracing, NSAIDs, physical therapy and activity modification. In addition, the EDS from April 2014 specifically noted moderate carpal tunnel syndrome.

Pre-Operative Medical Clearance: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, low back pain, preoperative testing, general.

Decision rationale: The patient is a 35 year old female with a documented diagnosis of diabetes. Based on this, a preoperative history and physical examination should be considered medical necessary to stratify the patient's risk and determine if further medical testing is 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, preoperative medical clearance should be considered medically necessary.

Post-Operative Physical Therapy for the Left Wrist, 2x4: Upheld

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

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

Decision rationale: As the left carpal tunnel release was 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 "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, 8 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.