

Case Number:	CM13-0018723		
Date Assigned:	01/03/2014	Date of Injury:	07/01/2002
Decision Date:	06/11/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	08/30/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and Hand Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient reported an injury on 11/06/1997. The mechanism of injury was noted to be the patient was picking up bumper stops made from cement and as he bent down to lift 1 of the cement stops, the patient felt a pop in his neck causing him to fall down and land on his knees. The patient had an EMG/nerve conduction study on bilateral upper extremities on 02/20/2013. The results were noted to include moderate left carpal tunnel syndrome with moderately prolonged left median motor and sensory nerve latencies across the wrist and very mild and minimal right carpal tunnel syndrome. The physical examination of 12/18/2013 revealed the patient had bilateral wrists with full range of motion and complaints of pain and numbness. The Durkan's, Phalen's, and Tinel's tests were positive bilaterally. There was flattening out of the thenar prominences bilaterally. The patient's diagnoses included bilateral carpal tunnel syndrome, both clinically and per nerve conduction EMG study of 02/20/2013, flexor tenosynovitis bilaterally, and bilateral palmar fasciitis. Documentation of 08/07/2013 revealed there was a request for a left carpal tunnel surgery, preoperative chest x-ray, pulmonary function test, electrocardiogram, preoperative evaluation, urinalysis, laboratory testing, a home exercise kit, TENS unit, wrist brace, smart glove, Micro Cool, DVT compression pump with sleeves, postoperative chiropractic/physiotherapy visits, postoperative acupuncture and postoperative medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) LEFT CARPAL TUNNEL RELEASE SURGERY TO INCLUDE LEFT WRIST FLEXOR SYNOVECTOMY WITH CARPAL TUNNEL RELEASE, DECOMPRESSION OF THE ARTERIAL ARCH, PALMAR ARCH, NEUROLYSIS OF THE MEDIAN NERVE, TENOLYSIS OF FLEXOR TENDON, AND FASCIOTOMY OF THE DISTAL ANTEBRACHIAL FASCIA: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome Chapter - Carpal Tunnel Release.

Decision rationale: ACOEM Guidelines indicate that a surgical decompression of the median nerves relieves CTS symptoms and carpal tunnel must be proved by positive findings on clinical examination and the diagnosis should be supported by a nerve conduction study before surgery is undertaken. The patient's nerve conduction study indicated he had moderate carpal tunnel syndrome. The specific criteria for carpal tunnel surgery were not provided. As such, secondary guidelines were sought. Official Disability Guidelines indicate for non-severe carpal tunnel syndrome a patient must have all of the following: "(1) symptoms requiring 2 of the following: abnormal KATZ hand diagram scores, nocturnal symptoms, and/or a flick sign, physical examination findings requiring a positive Phalen's and Tinel's, and initial conservative treatment requires 3 of the following: activity modification greater than 1 month, night wrist splint greater than 1 month, non prescription analgesia, home exercise training, or successful initial outcome from a corticosteroid injection and positive electrodiagnostic testing". The clinical documentation submitted for review indicated the patient had positive physical examination findings, and positive electrodiagnostic testing. There was a lack of documentation indicating the patient had an abnormal KATZ hand diagram score, nocturnal symptoms, or a flick sign and there was a lack of documentation indicating initial conservative treatments that were undertaken and the patient's response to those treatments. Given the above, the request for 1 Left Carpal Tunnel Release Surgery to include Left Wrist Flexor Synovectomy with Carpal Tunnel Release, Decompression of the Arterial Arch, Palmar Arch, and Neurolysis of the Median Nerve, Tenolysis of Flexor Tendon, and Fasciotomy of the Distal Antebrachial Fascia is not medically necessary and appropriate.

ONE (1) PRE-OPERATIVE CHEST X-RAY: 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 and appropriate.

ONE (1) PRE-OPERATIVE PULMONARY FUNCTION TEST (PFT): 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 and appropriate.

ONE (1) PRE-OPERATIVE ELECTROCARDIOGRAM (EKG): 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 and appropriate.

ONE (1) PRE-OPERATIVE EVALUATION: Overturned

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 and appropriate.

ONE (1) URINE ANALYSIS: 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 and appropriate.

ONE (1) PRE-OPERATIVE LABS: CBC, CHEM 12, PT AND PTT: 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 and appropriate.

ONE (1) HOME EXERCISE KIT: 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 and appropriate.

FIVE (5) MONTH RENTAL OF A TENS UNIT PLUS SUPPLIES: 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 and appropriate.

ONE (1) WRIST BRACE: 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 and appropriate.

ONE (1) SMART GLOVE: 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 and appropriate.

ONE (1) MICRO COOL: 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 and appropriate.

ONE (1) DVT COMPRESSION PUMP WITH SLEEVES: 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 and appropriate.

TWELVE (12) POST-OPERATIVE CHIROPRACTIC/PHYSIOTHERAPY VISITS FOR THE LEFT WRIST: 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 and appropriate.

TWELVE (12) POST-OPERATIVE ACUPUNCTURE VISITS FOR THE LEFT WRIST: 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 and appropriate.