

<b>Case Number:</b>	CM13-0024466		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	10/07/2009
<b>Decision Date:</b>	05/02/2014	<b>UR Denial Date:</b>	08/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, patient, providers or the claims administrator. The Physician Reviewer is Board Certified in Plastic and Reconstructive Surgery, and is licensed to practice in Maryland, North Carolina and Virginia. 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 Physician 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 is a 48 year old female with a reported date of injury on 10/7/09 due to reported repetitive trauma to the neck, shoulders, arms and hands as a public safety technician for the [REDACTED]. She has complained of ulnar sided bilateral wrist pain and bilateral numbness and tingling of the hands in the median nerve distribution, with the ride side complaints longer in duration than the left. Initial non-operative therapy included wrist bracing, cortisone injection, NSAIDs, physical and occupational therapy as well as work restrictions and modification of duties. Due to these problems as well as symptoms from the neck and lower extremities, she was eventually placed on total temporary disability. Due to cervical radiculopathy, she underwent neck surgery on June 21, 2012 with improvement in her pain and upper extremity complaints. Her right wrist pain and numbness progressed and was diagnosed with right ulnar impaction syndrome and right carpal tunnel syndrome. Electrodiagnostic studies from April 16, 2012 were stated as a normal study without evidence of entrapment neuropathy, peripheral neuropathy or radiculopathy. With continued symptoms, requests were made for surgical treatment and authorization was granted and thus underwent endoscopic tunnel release and arthroscopic abrasion chondroplasty of the right wrist on April 15, 2013. She had documented improvement in her right wrist pain and resolution of her right hand numbness following normal postoperative care and occupational therapy. During this time she was documented to continue with left wrist Final Determination Letter for IMR Case Number [REDACTED] ulnar sided pain and numbness in the median nerve distribution. MRI arthrogram on February 13, 2013 documented that the dorsal ulna was slightly subluxed and that there was an intrasubstance tear of the triangular fibrocartilage. X-rays of the wrist were noted as negative. She underwent continued non-operative therapy of the left wrist with NSAIDs, ice, occupational/physical therapy (in combination with her postoperative therapy after right wrist surgery) and chiropractor. She is

stated to have been evaluated by pain management of her upper extremities by [REDACTED]. Request for repeat electrodiagnostic studies was denied, dated 8/1/13, stating there is no objective documentation of radicular pain and there are no documented findings consistent with nerve compromise. Documentation from the requesting surgeon dated 8/13/13 notes previous MRI report from 3/8/13 that neck was without spinal stenosis or neuroforaminal stenosis. Utilization review dated 8/23/13 states left arthroscopic debridement of the left wrist and endoscopic carpal tunnel release are denied. Reason for denial stated as, "I do not find evidence of a surgically correctible lesion." "Minor changes were noted on MRI, but they do not appear to demand surgery. I do not see injection trials of exhaustion of conservative care." Agreed Medical Examination dated 9/24/13 notes radiating left wrist pain with numbness in 2nd through 5th digits. Pain and numbness awake the patient at night and the left wrist pain is progressing. Examination documents decreased sensation involving both hands, without evidence of thenar wasting. Assessment is that the proposed surgical treatment of carpal tunnel release and chondroplasty at the left wrist is appropriate and should be authorized. Further follow-up from the requesting surgeon dated 10/8/13 notes that the patient has greater left-sided ulnar wrist pain and Tinel's sign is positive. Utilization review dated 10/18/13 authorizes outpatient left wrist arthroscopic debridement with possible abrasion chondroplasty, left endoscopic carpal tunnel release and preop labs ... outpatient post-op physical therapy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **OUTPATIENT ARTHROSCOPIC DEBRIDEMENT OF THE LEFT WRIST WITH POSSIBLE ABRASION CHONDROPLASTY AND LEFT ENDOSCOPIC CARPAL TUNNEL RELEASE: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.dir.ca.gov/t8/ch4\\_5sb1a5\\_5\\_2.html](http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-270.

**Decision rationale:** The employee has a well-documented history of bilateral hand complaints attributed to a repetitive work history. The employee had similar complaints of both wrists. The employee underwent authorized right sided wrist surgery with improvement in her status, despite having documented normal electrodiagnostic studies. Initial reason given for denial of left-sided surgery was that there did not appear to be a surgically correctible lesion on MRI and that injection/conservative treatment was not well-documented. However, based on the review of the entire voluminous medical record including the MRI and the progression of symptoms on the left side and despite conservative treatment of NSAIDs, ice, bracing, modifying activity, I would argue that this is appropriate surgical treatment. This was supported by the AME and was later deemed appropriate on UR dated 10/18/13. The employee had signs of nerve entrapment of the median nerve at the wrist with corresponding numbness, positive Tinel's sign and nighttime symptoms. The employee had been documented to have undergone significant occupational/physical therapy. The employee's left wrist pain progressed as well despite this. There was no evidence of radiculopathy to suggest a double crush syndrome that would exclude

carpal tunnel release prior to treatment of the employee's neck. MRI examination documented a TFCC tear as well, a surgically correctable lesion. According to the ACOEM guidelines, the employee has symptoms consistent with carpal tunnel syndrome with numbness and tingling in the median nerve distribution. Clinical testing confirms altered sensory in these areas, along with a positive Tinel's sign. The employee has been documented to have performed repetitive activity that likely contributed to the symptoms while at work. NSAIDs were used as well as activity restriction and occupational/physical therapy. The employee's history and physical examination provide '++++' and '+++ (Number of plus signs indicates relative ability to identify or define pathology).respectively in identifying wrist/hand pathology for carpal tunnel syndrome (p 269, Table 11-1). Mild CTS with normal electrodiagnostic studies (EDS) exists (p. 270). Surgery will not relieve any symptoms from cervical radiculopathy (double crush syndrome), which as stated above appears to have been ruled out by MRI exam of the neck. Surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. I would argue that a definitive diagnosis has been made and that documented previous injection and splinting has failed. Finally, I would argue that similar trials had been performed for the left wrist pain including an exhaustive list of conservative management. There is a surgically correctable lesion as identified on MRI examination with a TFCC tear and the employee's symptoms have progressed warranting surgical correction. This appears consistent with the UR dated 10/18/13 In summary, by review of the ACOEM and discussed above, I would assert that the employee qualifies for surgical intervention on the left wrist and thus reverse the UR decision.

## **OUTPATIENT ELECTRODIAGNOSTIC TESTING OF BILATERAL UPPER EXTREMITIES:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.dir.ca.gov/t8/ch4\\_5sb1a5\\_5\\_2.html](http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Postsurgical Treatment Guidelines Page(s): 15, 22.

**Decision rationale:** The employee, as stated above, has signs and symptoms of significant left carpal tunnel syndrome. Although previous electrodiagnostic studies from 2012 were reported as normal, the employee has had progression/non-resolution of symptoms as documented above. The employee has undergone conservative management of splinting, activity restriction, NSAIDs and PT/OT with continued difficulty. As stated in ACOEM mild carpal tunnel syndrome exists with normal electrodiagnostic studies. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The employee has documented peripheral nerve impingement on clinical exam and has been present over a greater than 6 week period. Recommendations for further electrodiagnostic studies are made based on the progression of symptoms. This is consistent with ACOEM. Although a double crush syndrome is unlikely given the employee's previous neck surgery and MRI, this could also confirm that there is in fact no radiculopathy explaining the progression. The UR stated that there was no evidence of nerve compromise which is contradicted by the exam findings of numbness in the median nerve distribution and Tinel's sign being positive. In summary, based on the ACOEM and Post-Surgical Treatment Guidelines, electrodiagnostic testing of the bilateral upper extremities should be authorized.

**PRE-OP LABS: CBC, PT, PTT, INR, CHEM 7, URINALYSIS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back Pain, Preoperative lab testing.

**Decision rationale:** The employee is documented not to be taking any medications from a follow-up examination on 10/8/14. The employee is previously documented to have a history of palpitations and asthma. Previous history and physical dated 4/5/13 note a medication history of Tenormin. CXR was documented to be normal. Laboratory testing did not return significant abnormality and although EKG results were reported as sinus bradycardia no further intervention was documented. Based on the medical records reviewed, there was no further documentation to suggest any change in the employee's condition to warrant further preoperative laboratory testing, including CBC, PT, PTT, INR, Chem 7 or urinalysis. The requesting physician did not justify reasoning for ordering these tests. From ODG, Low Back Pain and preoperative laboratory testing: Is recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Criteria for preoperative lab testing: - Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. - Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. - Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. - In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. - A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. - Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. As stated above, the requesting physician has not documented the employee co-morbidities that would suggest preoperative laboratory testing. Thus, these tests should not be authorized.

**CHEST X-RAY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back Pain, Preoperative testing, General.

**Decision rationale:** The requesting surgeon has not documented a justification for obtain a CXR. Previous chest x-ray had been reported as normal and no further justification or change in the employee's condition has been documented. The employee has only previously been documented as having asthma with no reported medications or exacerbations. The requesting physician has not documented justification for a CXR and thus this should not be authorized.

**EKG:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back Pain, Preoperative electrocardiogram.

**Decision rationale:** The employee is noted to have been taking Tenormin for palpitations previously. A previous EKG was noted to be abnormal. Thus, to evaluate the employee's risk for surgery an EKG is warranted as supported by the ODG guidelines. The employee does have additional risk factors and thus a preoperative EKG is warranted and the surgery has been authorized.

**PREOPERATIVE MEDICAL CLEARANCE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back Pain, Preoperative testing, general.

**Decision rationale:** The employee has been authorized for a relatively low-risk procedure, based on the ODG guidelines. The employee does have a history of asthma, palpitations and abnormal EKG. Based on this and supported by ODG, a complete thorough examination is necessary to further stratify the employee's risk and order additional preoperative studies based on this. From ODG, these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Thus, a preoperative history and physical examination is justified as the surgery has been authorized.

**POST-OPERATIVE OCCUPATIONAL THERAPY (OT) THREE (3) TIMES PER WEEK OVER (4) WEEKS: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-270, Postsurgical Treatment Guidelines Page(s): 15, 22.

**Decision rationale:** With respect to postoperative therapy, this is addressed on pages 15 and 22 from Post-Surgical Treatment Guidelines Carpal Tunnel Syndrome. For Carpal tunnel syndrome 3-8 visits over 3-5 weeks is allowed and for TFCC injuries-debridement (arthroscopic) 10 visits over 10 weeks with a postsurgical physical medicine treatment period of 4 months. Since this is a combined surgery, it is reasonable to add these individual totals together, as the post-procedure therapy may be slightly different and add complexity to the recovery. Thus taking the maximum from CTS and TFCC debridement, 12 visits over 4 weeks is appropriate. Finally, the preoperative assessment and post-operative therapy was specifically approved in the UR review dated 10/18/13.