

Case Number:	CM13-0037159		
Date Assigned:	12/13/2013	Date of Injury:	02/24/2009
Decision Date:	02/11/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/23/2013

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, employee, providers or the claims administrator. The physician reviewer is Board Certified in Hand Surgery and is licensed to practice in Oregon. 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:

This female patient sustained an industrial injury on 02/24/09. The areas of injury include both wrists, both shoulders, cervical spine, lumbar spine, thoracic spine, and both knees. EMG testing was performed in 10/2/12 and showed evidence of moderate right and mild left carpal tunnel syndrome. The treatment included physical therapy, medications, bracing and corticosteroid injections. She complains of continued bilateral forearm, wrist, and hand pain with numbness and tingling, right worse than left. On examination, there is no evidence of swelling, atrophy, or deformity. There is tenderness over the wrist is minimal tenderness over the left first dorsal extensor compartment. Finkelstein's test is negative bilaterally. Tinel's sign over the carpal tunnel and Phalen's testing are positive bilaterally. Sensation is diminished in a median nerve distribution, right worse than left. Bilateral carpal tunnel releases are planned.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for Bilateral carpal tunnel release surgery: 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.

Decision rationale: The carpal tunnel releases are medically necessary. According to the ACOEM guidelines, Chapter 11, page 270, "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." This patient has significant symptoms of carpal tunnel syndrome, an exam consistent with carpal tunnel syndrome and positive electrodiagnostic studies for median nerve compression. Per the ACOEM guidelines, carpal tunnel release is medically necessary

pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative ECG and Preoperative Lab Testing and Other Medical Treatment Guideline or Medical Evidence.

Decision rationale: No guidelines were cited by the Claims Administrator. The Claims Administrator stated that since the surgery is not supported, the request for pre-operative medical clearance is not medically necessary. The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) Low Back, Preoperative ECG and Preoperative Lab Testing and Other Medical Treatment Guideline or Medical Evidence. The Physician Reviewer's decision rationale: Guidelines for preoperative testing for carpal tunnel syndrome are not included in ACOEM, MTUS and ODG. ODG supports selective testing for high-risk surgery. Carpal tunnel release is not high-risk surgery and the records do not document any unusual risk factors to justify preoperative testing. ODG, Low Back, Preoperative electrocardiogram (ECG) Recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013) 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. According to the "Practice advisory for preanesthesia evaluation. An updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation." (American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthes

Decision for a Coolcare cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Elbow Complaints, Heat and Cold Packs.

Decision rationale: MTUS and ACOEM do not address cryotherapy following carpal tunnel release. Per the ACOEM chapter titled "Elbow Complaints" page 27, "Only one quality study is available on cryotherapy and none on heat. Benefits have not been shown. These options are low cost (as at-home applications), have few side effects, and are not invasive. Thus, while there is insufficient evidence, at-home applications of heat or cold packs are recommended" At home cold packs should be sufficient for this patient.

post-operative rehabilitative therapy three (3) times per week for four (4) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for 12 visits exceeds the MTUS guidelines. Per the guidelines, 3-8 visits over 3-5 weeks is recommended.