

Case Number:	CM14-0101413		
Date Assigned:	07/30/2014	Date of Injury:	10/01/2012
Decision Date:	08/29/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/01/2014

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 is licensed to practice in California. 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:

This 55-year-old female sustained an industrial injury on 10/1/10, relative to cumulative trauma. The 8/10/12 bilateral upper extremity EMG/NCV showed mild bilateral carpal tunnel syndrome with no evidence of ulnar or peripheral neuropathy. The patient was status post right carpal tunnel release on 12/18/13 with good results. The 5/13/14 treating physician report cited left upper extremity intermittent numbness and tingling in the 3rd and 4th digits. There was grip strength weakness and sensation of fingers locking in the left hand. She reported frequently dropping things. There was 4+/5 left abductor pollicis brevis muscle weakness. There was positive Tinel's at the wrist and elbow. The 5/13/14 electrodiagnostic study revealed moderate median nerve compromise at the left carpal tunnel. The 5/22/14 treating physician report cited left wrist and hand pain with persistent intermittent numbness and tingling. Left wrist/hand exam documented volar and dorsal wrist tenderness and positive carpal tunnel compression. The patient had good response to a cortisone injection on 2/19/14. The 6/1/14 utilization review denied the request for left carpal tunnel release as the patient had failed to meet guideline criteria for surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Endoscopic assisted carpal tunnel release: Overturned

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

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

Decision rationale: The ACOEM guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Guideline criteria have been met. This patient presents with significant clinical exam findings of carpal tunnel syndrome, with electrodiagnostic evidence consistent with moderate carpal tunnel syndrome. Medication and restricted activities had been tried and failed. Therefore, this request for left endoscopic assisted carpal tunnel release is medically necessary.

Keflex 500mg Qty 20: 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 Medical Evidence: Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.

Decision rationale: The California MTUS does not provide guidance for post-operative antibiotics. The National Guideline Clearinghouse was searched. Clinical practice guidelines state that antimicrobial prophylaxis is not recommended for patients undergoing clean orthopedic procedures, including knee, hand, and foot procedures; arthroscopy; and other procedures without instrumentation or implantation of foreign materials. Guideline criteria have not been met. There is no guideline support for antibiotic prophylaxis in carpal tunnel release. Therefore, this request for Keflex 500mg #20 is not medically necessary.

Norco 10-325mg Qty 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines support the use of hydrocodone/acetaminophen (Norco) for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids: also known as normal-release or immediate-release opioids are seen as an effective method in controlling both acute and chronic pain. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guideline criteria have

been met for the post-operative use of Norco. Therefore, this request for Norco 10/325 mg #60 is medically necessary.

Post op occupational therapy visits Qty 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Initiating Therapy Page(s): 77-127.

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for carpal tunnel release suggest a general course of 3 to 8 post-operative visits over 3-5 weeks during the 3-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 4 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This initial request for post-operative occupational therapy visits exceeds the general course of treatment. Therefore, this request for 10 post-operative occupational therapy visits is not medically necessary