

<b>Case Number:</b>	CM14-0045194		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	05/26/2011
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 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 is a 47 year old female with a 5/26/11 date of injury. The patient does not describe a single traumatic event but instead attributes her injury to the cumulative effects of repetitive movements at her occupation. Since the date of injury, the patient was placed on modified duty but has not actually returned to work. In a QME report dated 11/19/13, the patient has subjective complaints of left greater than right hand numbness, tingling, and nighttime paresthesias. She has difficulty with manipulating small objects. She has a history of bilateral cervical radicular symptoms, and underwent C4-6 ACDF surgery on 4/25/13. She reports no significant improvement in her symptoms since the surgery. Documented objective findings are positive Durken's compression test bilaterally, positive Phalen's maneuver left greater than right, and a positive Tinel's sign at the median nerve on the left. There are no motor or sensory deficits. EMG/NCS on 8/25/11 of the upper extremities showed cervical radiculopathy and bilateral mild carpal tunnel syndrome. Diagnostic Impression: bilateral carpal tunnel syndrome, left greater than right. Treatment to date: medication management, home exercise, physical therapy, wrist splinting, C4-6 ACDF surgery on 4/25/13, left wrist cortisone injection on 3/31/14. A UR decision in March 2014 denied the request for left carpal tunnel release on the basis that the patient refused a left wrist cortisone injection earlier that month, and therefore had not had a sufficient trial of conservative treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Carpal Tunnel Syndrome Chapter.

**Decision rationale:** CA MTUS criteria for carpal tunnel release include failure of non-operative treatment or severe symptoms such as continuous tingling and numbness; most patients should have had at least 1 glucocorticosteroid injection; and patients who do not have a glucocorticosteroid injection that results in at least partial benefit should have an electrodiagnostic study (EDS) consistent with CTS. In the present case, the previous UR review denied authorization for surgery after a phone call placed to the physician's office determined that the patient had refused an initial left wrist cortisone injection. However, the physician progress notes one month afterwards clearly show that on 3/31/14, the patient accepted a left wrist cortisone injection. In a clinical follow-up on 4/21/14, the patient does not feel any significant improvement after the injection. In addition, the patient has not improved after other treatments have been tried, including night splinting, home exercises, and medication management. Since the patient has documented evidence of failing conservative treatment, it is appropriate to reverse the prior UR decision. Therefore, the request for left carpal tunnel release is medically necessary.

**Medical Pre Op Clearance:** Overturned

**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-Lumbar & Thoracic Chapter: Pre operative EKG and Lab testing. Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery.

**Decision rationale:** CA MTUS does not address this issue. ODG states that pre-op testing 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. Electrocardiography is 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. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change peri-operative management. The ACC/AHA 2007 Guidelines on peri-operative cardiovascular evaluation and care for non-cardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and

physical examination is warranted in those individuals 50 years of age or older. The prior UR decision denied the request for pre op medical clearance on the basis that the index procedure was denied. However, the decision on the index procedure has been reversed as described above. In addition, the patient has a history of hypertension, a risk factor for heart disease. Therefore, the request for medical pre op clearance is medically necessary.

**Assistant Surgeon:** Overturned

**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 Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

**Decision rationale:** CA MTUS does not address this issue. American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:-anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. The prior UR decision denied the request for assistant surgeon on the basis that the index procedure was denied. However, the decision on the index procedure has been reversed as described above. Therefore, the request for assistant surgeon is medically necessary.