Case Number:	CM15-0105230		
Date Assigned:	06/09/2015	**Date of Injury:**	12/29/2011
Decision Date:	07/10/2015	**UR Denial Date:**	05/05/2015
Priority:	Standard	**Application Received:**	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Maryland, Virginia, North Carolina
Certification(s)/Specialty: Plastic Surgery

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 49 year old female sustained an industrial injury to bilateral wrists and hands on 12/29/11. Previous treatment included magnetic resonance imaging, electromyography, left thumb metacarpal joint fusion, injections, bracing, therapy and medications. In a PR-2 dated 1/27/15, the injured worker was status post cortisone injections into the right wrist, left wrist and bilateral thumb carpometacarpal joint with persistent pain throughout. The injured worker also complained of continuing neck pain and swelling that developed after thumb surgery. The injured worker rated her pain 3-4/10 on the visual analog scale. Physical exam was remarkable for tenderness to palpation over the right thumb carpometacarpal joint with positive grind test and positive piano key test as well as tenderness to palpation over the triangular fibrocartilage complex. Current diagnoses included right thumb carpometacarpal and metacarpophalageal degenerative joint disease, status post left thumb MP joint fusion, left supraclavicular pain, left wrist extensor tenosynovitis, right carpal tunnel syndrome and bilateral wrist triangular fibrocartilage complex tears. The treatment plan included a diagnostic cortisone injection to the right carpal tunnel, and right endoscopic versus open carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right endoscopic versus open 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 (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: The patient is a 49 year old female with signs and symptoms of possible right carpal tunnel syndrome that has failed conservative management of splinting, NSAIDs, activity modification and steroid injection. She had been noted to have normal EDS studies of the right median nerve. As reasoned by the UR, given her positive response to the steroid injection and exhaustion of other conservative management, right carpal tunnel release in this patient is medically necessary despite being electrically negative. There is a subset of patients with carpal tunnel syndrome that have negative EDS. From page 270, ACOEM, Chapter 11, "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. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare". Further from page 272, Table 11-7, injection of corticosteroids into to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication.

Consultation for pre-operative 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 ODG, Low back pain, Preoperative testing, general.

Decision rationale: Based on the entirety of the medical record the patient is not noted to have evidence of significant illness that would require extensive work-up. However, a preoperative history and physical examination should be considered medical necessary to stratify the patient's risk and determine if further medical testing is necessary. From ODG guidelines and as general anesthesia is likely to be performed, preoperative testing should be as follows: An alternative to routine preoperative testing for the purposes of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. Thus, a preoperative medical clearance is medically necessary in the form of a history and physical to drive further testing.

Physical therapy 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 11, 16 and 17.

Decision rationale: As the carpal tunnel release was considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines: From page 15 and 16, Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Carpal tunnel syndrome (ICD9 354.0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks Postsurgical physical medicine treatment period: 3 months Postsurgical treatment (open): 3-8 visits over 3-5 weeks Postsurgical physical medicine treatment period: 3 months. "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. Therefore, based on these guidelines, 12 visits would exceed the initial course of therapy guidelines and is not medically necessary. Up to 4 visits would be consistent with these guidelines.