Case Number:	CM15-0130091		
Date Assigned:	07/16/2015	**Date of Injury:**	11/19/2012
Decision Date:	08/18/2015	**UR Denial Date:**	07/02/2015
Priority:	Standard	**Application Received:**	07/06/2015

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:

The injured worker is a 55-year-old male who sustained an industrial injury on 11/19/12. He had complaints of bilateral hand/wrist pain. Primary treating physician's progress report dated 5/5/15 reports continued complaints of bilateral hands with burning pain, weakness, numbness and tingling. Bracing has not relieved the symptoms. Diagnosis is severe bilateral carpal tunnel. Plan of care: surgery is recommended, will start with the right carpal tunnel release with plans for a left carpal tunnel release 3 months later. Work status: return to modified work on 5/5/15 with restrictions to avoid repetitive motion of bilateral wrists. Previous medical records documented an abnormal EKG with a conduction defect and medication for hypertension. He is on CPAP as well for obstructive sleep apnea. EDS from 7/28/14 were provided for this review and documented severe carpal tunnel syndrome with the right side greater than the left. Examination had noted bilateral hand numbness in the median nerve distribution with night symptoms and positive Durkan's, Tinel's and Phalen's signs with mild thenar atrophy. Conservative management had included bracing and NSAIDs (Aleve). Recommendation had been made for carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release: 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): 270 and 272.

Decision rationale: The patient is a 55-year-old male with signs and symptoms of severe right carpal tunnel syndrome that is supported by electrodiagnostic studies (EDS). Previous medical records documented an abnormal EKG with a conduction defect and medication for hypertension. He is on CPAP as well. EDS from 7/28/14 were provided for this review and documented severe carpal tunnel syndrome with the right side greater than the left. Examination had noted bilateral hand numbness in the median nerve distribution with night symptoms and positive Durkan's, Tinel's and Phalen's signs with mild thenar atrophy. Conservative management had included bracing and NSAIDs (Aleve). Recommendation had been made for carpal tunnel release. Based on the overall level of documentation, the patient satisfies medical necessity for right carpal tunnel release. The patient has evidence of severe bilateral carpal tunnel syndrome that is supported by examination findings and 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 are 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. The patient has failed conservative management of NSAIDs and bracing, but given the severe condition does not require a response to a steroid injection. Thenar atrophy and the documented EDS support a severe condition. Therefore, left carpal tunnel release is medically necessary. The UR review does not appear to have had records that were available for this review, clearly documenting a severe condition.

Postoperative physical therapy, 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 15 16.

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. From page 10, "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.

Preoperative labs: 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-TWC), Preoperative testing.

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 pain, Preoperative testing, general.

Decision rationale: The patient has a history of an abnormal EKG, as well as evidence of hypertension and obstructive sleep apnea. Preoperative laboratory studies may be indicated as the right carpal tunnel release is considered medically necessary. However, based on the documentation provided for this review the specific requested laboratory studies were not listed. Therefore, without the specific labs documented, this is not medically 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 history and physical may be necessary; to help to clarify which laboratory studies may be indicated.

Preoperative electrocardiogram (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-TWC), Preoperative testing.

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

Decision rationale: As the patient has a history of an abnormal EKG and has a history of hypertension and obstructive sleep apnea, a preoperative EKG should be considered medically necessary to compare to the previous one. Official Disability Guidelines (ODG) 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. As the patient has additional risk factors and a previous abnormal EKG, a preoperative EKG is medically necessary.