

Case Number:	CM15-0181428		
Date Assigned:	09/22/2015	Date of Injury:	03/14/2002
Decision Date:	11/09/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/15/2015

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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand 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 52-year-old female who sustained an industrial injury on 03-14-2002. Current diagnoses include status post right carpal tunnel release in 2008 and 02-28-2015, status post left carpal tunnel release in 2008 with recurring carpal tunnel syndrome, and sprain-strain cervical spine with radiculitis-radiculopathy. Report dated 08-21-2015 noted that the injured worker presented with complaints that included constant sharp pain in her neck, right wrist, and left wrist. Pain level was 9 (neck pain), and 8 (right wrist) out of 10 on a visual analog scale (VAS). Physical examination performed on 08-21-2015 revealed decreased range of motion in the right wrist, left wrist, and cervical spine with tenderness, Phalen's sign was positive in the left carpal tunnel, foraminal compression and Spurling's test were positive in the cervical spine, and tightness and spasm in the cervical spine. Previous diagnostic studies included an electrodiagnostic study performed on 07-16-2014. Previous treatments included medications and surgical intervention. The treatment plan included continued physical therapy for post operative right carpal tunnel release and neck exercises, pending authorizations for cervical spine epidural steroid injections, pending authorization for left wrist carpal tunnel release, laboratory evaluations, internal medicine consultation for surgical clearance, refilled medications which included Voltaren XR and Prilosec, and follow up in 6 weeks. The utilization review dated 08-27-2015, non-certified the request for left carpal tunnel release, surgical clearance-internal medicine consultation, 12 initial postoperative physical therapy for the left wrist, 2 times a week for 6 weeks, and postoperative use of wrist sling.

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: 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 Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The According to the ACOEM guidelines, 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.

Surgical Clearance/Internal Medicine Consultation: Upheld

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter - updated 5/15/15.

Decision rationale: The Official Disability Guidelines states that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations 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 that 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 perioperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease

that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose 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. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing. There is insufficient evidence to support routine preoperative medical clearance prior to straightforward hand surgery procedures. Therefore, the request is not medically necessary.

12 Post Operative Physical Therapy for the Left Wrist, 2 times a week for 6 weeks: Upheld

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 Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

Decision rationale: The Postsurgical Treatment 2009 Guidelines support up to 8 visits following carpal tunnel release. The records do not provide any justification or special circumstances to support exceeding the guidelines. Therefore, the request is not medically necessary.

Post Operative use of Wrist Sling: Upheld

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Tech Hand Up Extrem Surg. 2012 Jun;16(2):105-6. doi: 10.1097/BTH.0b013e31824e9f43. A modification of the collar-and-cuff sling to elevate the hand. Cooper L1, Ford KE, Sammut D.

Decision rationale: According to Cooper et al, Elevation of the hand is routinely sought after surgery and with pathology such as inflammation and infection. Many models of sling have been described. The collar-and-cuff model is a traditional low-cost method that is easily learned and applied, is versatile, and customized to each patient. It is, however, frequently misapplied so that it immobilizes the arm but does not produce sufficient elevation. The records do not document the type of sling planned and whether it will be modified to adequately elevate the hand following surgery. Therefore, the request is not medically necessary.