

<b>Case Number:</b>	CM15-0224948		
<b>Date Assigned:</b>	11/23/2015	<b>Date of Injury:</b>	10/15/2014
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/16/2015

### 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(n) 67 year old female, who sustained an industrial injury on 10-15-14. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, bilateral ulnar neuropathy and peripheral nerve compression, ulnar and median bilaterally with positive electromyography. Subjective findings (7-1-15, 7-29-15, 8-18-15 and 9-21-15) indicated bilateral wrist pain rated 7-8 out of 10 with numbness and tingling in the hands. Objective findings (7-1-15, 7-29-15, 8-18-15 and 9-21-15) revealed right wrist flexion was 35-60 degrees, extension was 35-60 degrees, radial deviation was 10-20 degrees and ulnar deviation was 20-30 degrees. Left wrist range of motion was 35-60 degrees of flexion, 35-60 degrees of extension, 10-20 degrees of radial deviation and 20-30 degrees of ulnar deviation. There was also a positive Phalen's and Tinel's sign in the bilateral wrists. As of the PR2 dated 10-6-15, the injured worker reports bilateral elbow pain rated 5 out of 10, with radiation to the bilateral upper extremities and constant bilateral wrist and hand pain rated 5 out of 10. Objective findings include a positive Tinel's sign in the bilateral elbows at the ulnar nerves and a positive Tinel's sign in the bilateral wrists with radiation to the median distribution. The treating physician recommended a left side carpal tunnel release with ulnar nerve release and transposition and post-operative Tylenol #4. Treatment to date has included a home exercise program, Soma and Norco. The Utilization Review dated 10-27-15, non-certified the request for an assistant surgeon and modified the request for Tylenol #4 qty 60 to Tylenol #4 qty 40.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Assistant surgeon:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back: Surgical Assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Book Chapter, Basic Surgical Technique and Postoperative Care. David L. Cannon Campbell's Operative Orthopaedics, Page Number: Chapter 64, 3200-3220.

**Decision rationale:** The patient is a 67 year old female who was certified for left carpal tunnel release and left cubital tunnel release. An assistant surgeon was not certified. ACOEM guidelines do not specifically address the use of an assistant surgeon. Thus, alternative evidence was reviewed. From the above reference with respect to hand surgery, the role of the assistant surgeon is defined: 'Seated opposite the surgeon, the assistant should view the operative field from 8 to 10 cm higher than the surgeon to allow a clear line of vision without having to bend forward and obstruct the surgeon's view. Although mechanical hand holders are available, they are not as good as a motivated and well-trained assistant. It is especially helpful for the assistant to be familiar with each procedure. Usually, the primary duty of the assistant is to hold the patient's hand stable, secure, and motionless, retracting the fingers to provide the surgeon with the best access to the operative field.' Thus, the role and importance of an assistant surgeon is well-defined and should be considered medically necessary. Although carpal tunnel release and cubital tunnel release may be considered a relatively non-complex surgery, complications can arise from injury to the median nerve, ulnar nerve or its branches, as well as the vasculature of the hand. Thus, an assistant can help to prevent this and should be considered medically necessary. The UR states that based on ODG guidelines for low back pain, assistant surgeons are an option for more complex surgeries. Based on the critical anatomic structures of the median and ulnar nerves, their protection from injury is critical and thus, an assistant should be considered medically necessary to help prevent injury.

**Tylenol #4 Qty: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** The patient is a 67 year old female who was certified for left carpal tunnel release and left cubital tunnel release. Tylenol #4, #60 was not certified but modified to #40. From ACOEM guidelines, page 47-48, Chapter 3, Initial approaches to Treatment: Opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. Opioids cause significant side effects, which the clinician should describe to the patient before prescribing them. Poor patient tolerance, constipation, drowsiness, clouded judgment, memory loss, and potential misuse or dependence has been reported in up to 35% of patients. Patients should be informed of these potential side effects. As postoperative analgesia is necessary to control possible significant pain following surgery, opioids should be necessary. However, as stated above, they should be used only for a short time. Carpal tunnel release and cubital tunnel release is not generally associated with significant long-term pain. Thus, a quantity of 60 does

not appear consistent with a short time period and should not be considered medically necessary.