

<b>Case Number:</b>	CM15-0040222		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	10/15/2013
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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 59 year old male, who sustained an industrial injury on October 15, 2013. He reported left shoulder, elbow and wrist pain. The injured worker was diagnosed as having pain in the left shoulder joint, left shoulder sprain/strain, epicondylitis of the left elbow, left elbow sprain/strain and left wrist and hand sprain and strain. Treatment to date has included radiographic imaging, diagnostic studies, conservative therapies, pain medications and work restrictions. Currently, the injured worker complains of continued left shoulder, elbow and wrist pain. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. He noted being a teacher. He walked into the classroom and was struck with a chair by a student. He noted blocking the chair with his left upper extremity. He had immediate pain and started physical therapy. He reported no significant improvement with physical therapy. Evaluation on January 27, 2014, revealed continued pain. Electrodiagnostic studies revealed carpal tunnel syndrome. Carpal tunnel release was recommended. Electrodiagnostic studies from 1/20/14 note a moderate compression of left median nerve at the carpal tunnel. Previous evaluation dated 8/11/14 noted a blood pressure of 177/87 and was previously authorized for left carpal tunnel release and had undergone a cardiac clearance. Documentation from 1/26/15 note conservative management has included medical management (pain pills and Motrin), splinting, activity modification and physical therapy. He could not undergo his previously authorized surgery due to personal issues. Previous documentation also supported that he had had a home exercise program prescribed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left carpal tunnel release with tenosynovectomy, median nerve neurolysis and pre-operative medical clearance:** 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 Page(s): 265 and 270. Decision based on Non-MTUS Citation Carpal tunnel syndrome Low back pain, preoperative testing, general.

**Decision rationale:** The patient is a 59 year old male with a well-documented clinical picture of moderate left carpal tunnel syndrome that has failed conservative management and is supported by electrodiagnostic studies. Conservative management has included splinting (nighttime as well), medical management including NSAIDs, physician-prescribed home exercise program, activity modification and physical therapy. He satisfies ACOEM guidelines for carpal tunnel release: From Chapter 11, page 270, CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Corticosteroids may be used to facilitate the diagnosis as stated from page 265: Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. Based on the overall level of documentation and supporting electrodiagnostic studies, it is not necessary to confirm the diagnosis. This is supported by ODG as a steroid injection is considered optional as another determinant of failed conservative measures. This patient is well documented to have failed an exhaustive list of other conservative management. Specifically, ODG states 'Initial relief of symptoms can assist in confirmation of the diagnosis and can be a good indicator of success of surgery if electrodiagnostic testing is not readily available.' For this patient, electrodiagnostic studies provided support for the diagnosis and the patient had failed other reasonable forms of conservative management. Therefore, left carpal tunnel release in this patient should be considered medically necessary. The UR stated that the patient was not documented to have failed conservative management as outlined by ODG. It appears earlier medical records were available for this review that were not available to the UR, which confirmed conservative management of splinting, NSAIDs (medical management), home exercise program and activity modification. With respect to preoperative medical clearance, the patient is 59 years old with a history of hypertension that appears to be poorly controlled. As general anesthesia may be performed, a preoperative medical clearance is consistent with ODG, preoperative testing as follows: 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. Thus, preoperative medical clearance should be considered medically necessary. As the patient had previously been evaluated by cardiology, it is reasonable to have an updated evaluation from them.

**Post-op physical therapy x 8 to left upper extremity:** Upheld

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

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

**Decision rationale:** As left carpal tunnel release is considered medically necessary, post-op physical therapy is indicated based on the following guidelines: 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 therapy is 1/2 the number of allowed visits within the initial treatment period. Thus, 2-4 visits would be considered medically necessary. Therefore, 8 visits would exceed these guidelines and should not be considered medically necessary.

**Associated surgical service: Purchase of wrist splint:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

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

**Decision rationale:** The patient is a 59 year old male with medically necessary surgical treatment of left carpal tunnel syndrome. ACOEM page 270 addresses postoperative splints following carpal tunnel release: Two prospective randomized studies show no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home therapy program. Therefore, a postoperative splint should not be considered medically necessary.