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| Case Number: | CM15-0059807 | | |
| Date Assigned: | 04/10/2015 | Date of Injury: | 05/09/2008 |
| Decision Date: | 05/06/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/30/2015 |

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 50-year-old female, who sustained an industrial injury on 05/09/2008. Treatment to date has included electrodiagnostic testing, cortisone injection and physical therapy. Currently, the injured worker complains of persistent bilateral carpal tunnel syndrome despite the previous corticosteroid injection and therapy. The cortisone injection did not make significant difference at all. She was still experiencing numbness and tingling on both hands median nerve distributions with severe burning pain and frequent night awakening. She reported her right hand had become significantly weaker with some loss of dexterity. There was significant swelling of the bilateral volar distal forearm with worsening carpal tunnel syndrome, indicative of flexor tenosynovial proliferations. She had positive Tinel and Phalen sign across the bilateral carpal tunnel. Phalen and Durkan's maneuver elicited burning pain, radiating up along the volar forearm and upper lateral arm area, none over the Guyon's canal. Treatment plan included surgery. Currently under review is the request for bilateral median nerve block x 2, synovectomy x 2 and associated surgical service.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral median nerve block x2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Int Anesthesiol Clin. 2012 Winter;50(1):47-55. doi:10.1097/AIA.0b013e31821a00a8. Outpatient Regional Anesthesia for Upper Extremity Surgery Updated (2005 to present) distal to shoulder. Maga JM, Cooper L, Beghard RE. Source Department of Anesthesiology, University of Miami Hospital, Miami, Florida, USA. last updated 12/01/2012.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation From the American Society of Plastic Surgeons(ASPS):Printed in Plastic Surgery News - May 1999What's global in coding carpal tunnelsurgery?By Raymond Janevicius, MD.

Decision rationale: The patient is a 50 year old female who was certified for bilateral carpal tunnel release. The request was for a bilateral median nerve block. A median nerve block as a form of regional anesthesia can be considered medically necessary. However, as the surgeon is performing the carpal tunnel release and the median nerve block, the nerve block would be considered integral to the procedure and part of the global coding as reported in Plastic Surgery News 1999. 'A straightforward "standard" open carpal tunnel release is coded 64721. This global code clearlyincludes: The approach (incision, division of the palmar aponeurosis). Antebrachial fasciotomy. Division of the transverse carpal ligament. Exploration of the motor branch. Release of the motor branch (fibrous bands, transligamentous course). External neurolysis. Epineurotomy. Synovial biopsy or limited synovectomy. Closure of the operative wound. Application of wrist splint. Anesthesia (local/wrist block) provided by the surgeon. 90 days of uncomplicated postoperative care (office visits, wound checks, bandage changes, suture removal). Therefore, bilateral median nerve block is not medically necessary when performed by the operating surgeon.

Synovectomy x2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Bone Joint Surg AM 2002 Feb;84-A(2):221-5. The role of flexor tenosynovectomy in the operative treatment of carpal tunnel syndrome.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MOC-PS(SM) CME Article: Self-Assessment and Performance in Practice: The Carpal Tunnel Hentz, Vincent R.; Lalonde, Don H.Plastic & Reconstructive Surgery. 121(4):1-10, April 2008.

Decision rationale: The patient is a 50-year-old female who was certified for bilateral carpal tunnel syndrome. The requesting surgeon noted that the patient had swelling of the wrists and worsening of carpal tunnel syndrome that was stated to be a sign of flexor tenosynovial proliferation. As documented above, a limited synovectomy is part of the global coding for carpal tunnel release. In addition, as reasoned in the UR, there is no evidence that performing a synovectomy provides any benefit to the patient. From Hentz VR, 2008, with respect to ancillary procedures: Synovectomy of the Flexor Tendons. This was advocated more in the past. There are studies that demonstrate that routine flexor synovectomy adds nothing beneficial to the

outcome and may serve to increase the morbidity associated with the procedure. Synovectomy may be indicated at the time of carpal tunnel release in those conditions associated with very exuberant tenosynovitis, such as rheumatoid arthritis or amyloidosis, as in renal failure patients. Based on the overall level of documentation provided, there is not sufficient evidence that a synovectomy is indicated for this patient and is not medically necessary.

Associated surgical service: Cold therapy compression unit rental x 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation ODG-TWC Carpal Tunnel Syndrome Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, carpal tunnel syndrome, continuous cold therapy.

Decision rationale: The patient is a 50-year-old female who was certified for carpal tunnel release. A cold therapy compression unit rental was requested for 30 days. From ODG, continuous cold therapy is only recommended for post-operative use and for no more than 7 days. Therefore, the request is not consistent with the guidelines. Therefore, cold therapy compression for 30 days is not medically necessary.