

Case Number:	CM15-0087795		
Date Assigned:	05/12/2015	Date of Injury:	01/29/2015
Decision Date:	06/29/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/07/2015

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: California

Certification(s)/Specialty: Orthopedic Surgery, Hand Surgery, Sports Medicine

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 53 year old female, who sustained an industrial injury on January 29, 2015. She reported hearing an audible pop when she forcefully grasped a tray cart, with sudden severe right volar wrist pain. The injured worker was diagnosed as having right wrist sprain, right carpal tunnel syndrome, right ulnar neuropathy, and tendinitis of the right wrist. Treatment to date has included physical therapy, splinting, nerve conduction study (NCS), and medication. Currently, the injured worker complains of ongoing volar wrist and forearm pain. The Primary Treating Physician's report dated April 10, 2015, noted the injured worker reported Motrin had been helpful with less pain and swelling, still barely able to do her activities of daily living (ADLs). The injured worker was noted to have completed 12/12 physical therapy visits. Physical examination was noted to show an abnormal exam of the right forearm and inner elbow with pain and tenderness to mild palpation, a positive right cubital tunnel Tinel's, and carpal tunnel compression noted to cause pain and paresthesias. A nerve conduction study (NCS) on March 17, 2015, was noted to show right carpal tunnel syndrome with focal axon denervation, without evidence of ulnar neuropathy. The treatment plan was noted to include the Provider concurring with the orthopedic evaluation March 31, 2015, for an open right carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right open carpal tunnel release: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (Acute & Chronic), Indication for Surgery -- Carpal Tunnel Release.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: In this case, I recommend overturning the prior UR decision. The records provided are inconsistent and unusual. For example, symptoms are reported to have begun with a single incident of grasping and pulling, but such a mechanism does not cause carpal tunnel syndrome. However, both the initial evaluating physician and the treating surgeon note that symptoms predated the January 29, 2015 incident and were likely simply aggravated on that date. The injured worker has had routine symptomatic treatment including activity modification, oral anti-inflammatory medications, supervised therapy and splinting, but symptoms are persistent. Although just mildly abnormal, the March 17, 2015 electrodiagnostic testing demonstrated slowing of median sensory conduction consistent with a component of carpal tunnel syndrome. While the March 31, 2015 surgical request just 2 months after the reported sudden onset of symptoms was a bit premature, it has now been 5 months since symptoms began and consideration of surgery is reasonable. The California MTUS notes that, "high quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of carpal tunnel syndrome." Therefore, it is my recommendation that the surgery is medically necessary.

Surgical Assistant: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule Search, CPT Code 64721, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Green's Operative Hand Surgery, 6th ed Pages 989-991.

Decision rationale: Surgical technique is beyond the scope of the California MTUS guidelines; surgical details are discussed in the specialty text referenced. A surgical assistant is not necessary for carpal tunnel release. Even when performed with a larger "open" surgical technique, a typical incision would be about 1 inch long.

Pre-operative EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery. American College of Cardiology

Foundation - Medical Specialty Society and on the Non-MTUS American Heart Association - Professional Association. 1996 Mar 15 (revised 2007 Oct). 83 pages. NGC:005963.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative Testing Before Noncardiac Surgery: Guidelines and Recommendations MOLLY A. FEELY, MD; C. SCOTT COLLINS, MD; PAUL R. DANIELS, MD; ESAYAS B. KEBEDE, MD; AMINAH JATOI, MD; and KAREN F. MAUCK, MD, MSc, Mayo Clinic, Rochester, Minnesota Am Fam Physician. 2013 Mar 15; 87(6):414-418.

Decision rationale: An extensive systematic review referenced above concluded that there was no evidence to support routine preoperative testing. More recent practice guidelines recommend testing in select patients guided by a preoperative risk assessment based on pertinent clinical history and examination findings, although this recommendation is based primarily on expert opinion or low-level evidence. In this case, there is no documented medical history to support the need for the requested evaluation; rather, records indicate no substantial medical history. Therefore, the request is not medically necessary.