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| <b>Case Number:</b>   | CM15-0129282 |                              |            |
| <b>Date Assigned:</b> | 08/03/2015   | <b>Date of Injury:</b>       | 08/01/2012 |
| <b>Decision Date:</b> | 09/24/2015   | <b>UR Denial Date:</b>       | 06/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/07/2015 |

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 38 year old, female who sustained a work related injury on 8-1-12. The diagnoses have included generalized non-convulsive epilepsy and wrist strain/sprain. Treatments have included wrist bracing, 14 physical therapy sessions and oral medications. In the Primary Treating Physician's Comprehensive Orthopedic Evaluation dated 5/20/15, the injured worker reports right hand and wrist pain. She rates the pain level a 5 out of 10. She has been taking Naproxen for pain and discomfort since last visit. On physical exam, she has normal range of motion in right wrist and hand. She has a positive Phalen's and Tinel's signs which elicits some neuropathic type pain over median distribution. She also presents with cubital tunnel, clinically, as she experiences electric type pain radiating down to ulnar nerve distribution of the right arm as well. She is working with restrictions but she is not able to perform certain aspects of the job. She has to delegate activities that require repetitive gripping type activities. EMG done on 10-31-14 indicated findings consistent with a "very mild median nerve injury at or near the wrist on the right" and revealed bilateral mild carpal tunnel at the wrist. The treatment plan includes right wrist surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexor tenosynovectomy of the right wrist and hand with carpal tunnel release, decompression of the arterial arch, neurolysis of the median nerve, tenolysis of the flexor tendon of the right wrist and hand, fasciotomy of the distal antebrachial tascia of the right wrist, and exploration with epineur:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Carpal Tunnel Release Surgery (CTR) and Forearm, Wrist and Hand, Tenolysis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome.

**Decision rationale:** CA MTUS/ACOEM do not specifically address neurolysis. According to ODG, Carpal Tunnel syndrome, Carpal Tunnel Release Surgery, Adjunctive procedures: The 2008 AAOS CTS clinical treatment guidelines concluded that surgeons not routinely use the following procedures when performing carpal tunnel release: Skin nerve preservation; & Epineurotomy. The following procedures had no recommendation for or against their use: Flexor retinaculum lengthening; internal neurolysis; Tenosynovectomy; & Ulnar bursa preservation. Therefore, neurolysis and tenosynovectomy is not recommended and the combined request by the treating physician is not medically necessary.

**Pre-operative chest x-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative EKG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative PFT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative urinalysis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative DME: IFC:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative DME: micro cool:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative DME: DVT compression pump and stockings:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative physiotherapy (3 times per week for 4 weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative acupuncture (2 times per week for 6 weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative medication: Keflex 500mg #20: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-operative medication: Norco 5/325mg #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.