

Case Number:	CM15-0099268		
Date Assigned:	06/01/2015	Date of Injury:	09/06/2014
Decision Date:	06/30/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/22/2015

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 49 year old female who sustained a repetitive industrial injury on 09/06/2014. The injured worker was diagnosed with bilateral carpal tunnel syndrome. The injured worker failed conservative measures consisting of physical therapy, bracing, home exercise program and medications and according to the documentation underwent a left carpal tunnel release on February 19, 2015 followed by post-operative physical therapy. According to the primary treating physician's progress report on April 3, 2015, the injured worker's left hand is improving post-surgery and she continues to be symptomatic in her right hand and wrist. Examination of the left wrist demonstrated slight tenderness over the incision with normal sensory to the median nerve distribution. The injured worker stated she was ready to undergo surgery for her right wrist. Current medications were not discussed and the injured worker remains on temporary total disability (TTD). The current request is for associated services related to the left carpal tunnel release performed in February 2015 consisting of a pre-operative chest X-ray and Electrocardiogram (EKG) and post-operative physical therapy three times a week for 4 weeks (12 visits) for the left wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Chest X-Ray: Upheld

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, Online Version, Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, low back pain, preoperative testing, general.

Decision rationale: The patient is a 49 year old female who was certified for left carpal tunnel release. A CXR had been requested. There is minimal supporting documentation that the patient would need a CXR prior to a left carpal tunnel release. The patient's medical history includes hypertension. No further detail with respect to her hypertension was documented in the medical record. The patient is not noted to be taking any medications and is without any major illnesses other than hypertension. There is insufficient documentation/justification for a CXR. The medical history does not provide detail that the patient would be at risk for pulmonary complications or that the patient has a medical condition that would require evaluation with a CXR. The planned surgical procedure should be considered low risk in an ambulatory patient. Thus, without further clarification related to the reason for ordering the CXR, this should not be considered medically necessary. ODG, preoperative testing, general: Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Therefore, as there is not sufficient documentation that the patient is at risk of postoperative pulmonary complication or has a medical history that warrants a work-up to include a CXR, this should not be considered medically necessary. If, on history and physical examination, there is some concern for a pulmonary issue, this could be reconsidered.

Associated surgical service: EKG: Upheld

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, Online Version, Preoperative electrocardiogram (ECG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, preoperative electrocardiogram(ECG) ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

Decision rationale: The patient is a 49 year old female who was certified for left carpal tunnel release surgery, which is a relatively low-risk surgical procedure. There is minimal documentation that the patient has medical comorbidities other than hypertension. However, under medication history the patient is not noted to be taking medications. From ODG, Preoperative electrocardiogram (ECG): Recommended for patients undergoing high-risk surgery

and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013) Based on the medical records reviewed, there is not sufficient evidence to warrant ECG. The patient is undergoing a low-risk procedure and has only a stated history of hypertension. The patient is not noted to have symptoms of cardiac disease. Further from ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery: Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Thus, based on the medical records provided, ECG should not be considered medically necessary. However, a medical examination was certified and based on this more complete evaluation, if the conditions warrant, a reevaluation could be considered.

Post-Operative Physical Therapy, 3 times a week for the Left Wrist QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 11, 15 and 16.

Decision rationale: The patient is a 49 year old female who was certified for left carpal tunnel release. As the carpal tunnel release was considered medically necessary, postoperative physical therapy should be considered medically necessary based on the following guidelines: From page 15 and 16, Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. 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 course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. Therefore, based on these guidelines, the requested 12 visits would exceed the therapy guidelines and should not be considered medically necessary.

