MAXIMUS Federal Services

Case Number:	CM13-0002836		
Date Assigned:	12/27/2013	Date of Injury:	11/24/2012
Decision Date:	03/18/2014	UR Denial Date:	07/05/2013
Priority:	Standard	Application Received:	07/24/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California, DC, Maryland, and Florida. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 51 year old male forklift operator/Caro Handler with the [redacted] who was injured on 11/24/12. Diagnostics consisted of an MRI on 3/7/2013 which showed cervical spine: C5-6 degenerative dehiscence, 2 mm central disc protrusion indenting the anterior portion of the cervical subarachnoid space, C6-7 degenerative dehiscence, 2.5 mm central disc protrusion indenting the anterior portion of the cervical subarachnoid space, mild bony hypertrophy of the articular facets, and mild lateral recess stenosis. MRI left shoulder showed mild impingement syndrome and tendinosis of the rotator cuff without tear. 07/011/13 note from [redacted]: Subjective Findings: [redacted] reports constant pain in the neck area. The patient describes the pain as aching and he rates the pain as 8-9 out of 10 on a visual analog pain scale of 0-10 with 0 being no pain and 10 being most severe. The pain extends to his left shoulder and increases with sitting. Objective Findings: Physical examination of the cervical spine reveals decreased lordosis. There is no asymmetry of the Web outline of the neck. Palpation of the cervical spine reveals tightness, spasm, muscle guarding at trapezius, sternocleidomastoid and strap muscles, bilaterally. There is no sub-occipital triangle tenderness. There is no tenderness of spinal processes of cervical vertebrae. There is no evidence of swelling of supraclavicular fossa. Positive Spurling's test. Positive Foramina compression test.

IMR ISSUES, DECISIONS AND RATIONALES

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

carpal tunnel release left wrist QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Carpal Tunnel Syndrome Page(s): 15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section on TWC-Carpal Tunnel Syndrome (Acute & Chronic) (updated 2/20/14) Carpal Tunnel Syndrome

Decision rationale: Guideline criteria have not been met as evidence of CTS diagnosis and of a recent comprehensive non-operative treatment protocol trial and failure has not been documented. ODG guidelines recommends the following initial conservative treatment, requiring three of the following: 1. Activity modification for greater than 1 month, 2. Night wrist splint greater than 1 month, 3. Nonprescription analgesia (i.e., acetaminophen), 4. Home exercise training (provided by physician, healthcare provider or therapist), 5. Successful initial outcome from corticosteroid injection trial (optional). Initial relief of symptoms can assist in confirmation of diagnosis and can be a good indicator for success of surgery if electrodiagnostic testing is not readily available. Based on the above guidelines, the request for Carpal Tunnel release surgery is not medically necessary.

left shoulder arthroscopic surgery subacromial decompression QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Shoulder (Acute and Chronic) Surgery for impingement syndrome

Decision rationale: Guideline criteria have not been met as evidence of a recent comprehensive non-operative treatment protocol trial and failure has not been documented. CA-MTUS states "Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks." ODG recommends conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature along with other exercise guideline recommendation. Therefore, this request is not medically necessary at this time.

hot/cold contrast unit QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG TWC Treatment - Integrated Treatment/Disability Duration Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Shoulder (Acute & Chronic) (updated 01/20/14) Continuous-flow cryotherapy

Decision rationale: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Since surgery is not recommended, this request is not medically necessary at this time.

wrist brace QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Carpal Tunnel Syndrome, page(s) 65 and 270; Official Disability Guidelines (ODG)

Decision rationale: Regarding the request for wrist brace, the guideline is not supportive. There is no evidence that the diagnosis of carpal tunnel syndrome has been confirmed in this patient. According to CA-MTUS, wrist brace is recommended as an initial therapy in patients with mild carpal tunnel syndrome. ODG states: "Recommend splinting of wrist in neutral position at night & day prn, as an option in conservative treatment. Use of daytime wrist splints has positive, but limited evidence". Therefore the request for wrist brace is not medically necessary.

Internal Medicine Consult QTY1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), California Guidelines Plus, Section on Consultation

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 3rd Edition, 2011chapter 7, Section on Independent Medical Examination and Consultation

Decision rationale: In the medical report dated May 01, 2013, the treating physician stated:"I prescribe an Internal Medicine Evaluation for surgical Clearance. This evaluation is to address the co-morbidity of any existing medical conditions, whether diagnosed or undiagnosed, as the risk of complications during the procedure need to be minimized. Any existing medical condition needs to be controlled prior to undergoing any procedure. However, since the surgical procedure

to be performed for which this Internal Medicine clearance is requested was not approved, the Internal Medicine consult is not medically necessary.