MAXIMUS Federal Services

Case Number:	CM14-0153300		
Date Assigned:	09/23/2014	Date of Injury:	03/26/1999
Decision Date:	10/24/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/19/2014

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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Nephrology, and is licensed to practice in California. 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/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:

This is a 62 year old female with a 3/26/99 injury date. The mechanism of injury was not provided. In a 6/16/14 follow-up, the patient complained of aching right shoulder pain of 8-9/10 severity with numbness, pins, and needles, and right wrist pain of 8-9/10 severity. Objective findings included tenderness over the sternoclavicular and acromioclavicular joint tenderness, right shoulder crepitus, and right shoulder decreased range of motion in all fields. There are positive impingement signs and full strength. Right wrist Tinel's and Phalen's tests were positive, and there was decreased sensation in the median nerve distribution. Grip strength was found to be 3/5. In an 8/1/14 follow-up, subjective complaints included right shoulder, right wrist, and right hand pain. The patient reported worsening of symptoms and difficulty with wrist range of motion over the past 2-3 weeks, and noticed a clicking sensation in the wrist. Objective findings were unchanged from the prior exam. An EMG (7/23/14) noted a possible recurrence of right carpal tunnel syndrome. Diagnostic impression: right carpal tunnel syndrome, right shoulder pain. Treatment to date: right carpal tunnel release (2000), medications. A UR decision on 8/26/14 denied the request for revision right carpal tunnel release with possible neurolysis, microscopic, on the basis that it was not documented that the patient had completed an appropriate course of conservative treatment. The requests for Zofran, Duracef, Norco, Sprix, physical therapy, and acupuncture were denied because they are intended for the post-op period and the surgical procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

REVISION RIGHT CARPAL TUNNEL RELEASE WITH POSSIBLE NEUROLYSIS, MICROSCOPIC: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

MAXIMUS 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 Chapter

Decision rationale: The California MTUS criteria for carpal tunnel release include failure of non-operative treatment or severe symptoms such as continuous tingling and numbness; most patients should have had at least 1 glucocorticosteroid injection; and patients who do not have a glucocorticosteroid injection that results in at least partial benefit should have an electrodiagnostic study (EDS) consistent with CTS. However, in the present case, there is no recent documentation of prior physical therapy, wrist splinting, or cortisone injection. In the latest follow-up note, the provider indicates that the patient will start wrist night splinting, but there is no follow-up documentation with a discussing of the effects of the treatment. Although the current wrist complaints may represent a recurrence of carpal tunnel syndrome since the 2000 carpal tunnel release surgery, a full trial of conservative therapy is still warranted prior to considering revision surgery. Therefore, the request is not medically necessary.

ZOFRAN 8MG ONE (1) Q8HRS PRN POST OP NAUSEA #10: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA (Odansetron)

Decision rationale: As the original request is not medically necessary, all related requests are considered to be medical unnecessary.

DURACEF 500MG ONE (1) BID FOR SEVEN DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nlm.nih.gov/pubmed/21975095

Decision rationale: As the original request is not medically necessary, all related requests are considered to be medical unnecessary.

NORCO 10/325MG ONE (1) Q4-6HRS #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48,Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: As the original request is not medically necessary, all related requests are considered to be medical unnecessary.

SPRIX NASAL SPRAY 15.75MG 40 UNITS (5 BOTTLES): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA (Sprix).

Decision rationale: As the original request is not medically necessary, all related requests are considered to be medical unnecessary.

PHYSICAL THERAPY TWO 92) TIMES A WEEK FOR FOUR (4) WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: As the original request is not medically necessary, all related requests are considered to be medical unnecessary.

ACUPUNCTURE TWO (2) TIMES A WEEK TO RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204,Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter

Decision rationale: The California MTUS does not consistently and overwhelmingly support the use of acupuncture in the management of shoulder injuries. However, the Official Disability Guidelines (ODG) state that among those shoulder indications found to have positive outcomes from acupuncture were rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following arthroscopic acromioplasty. Additionally, the ODG supports an initial trial of 3 to 6 visits. In this case, the proposed acupuncture is not related to treating the right wrist carpal tunnel symptoms but, instead, the right shoulder symptoms. The documentation

suggests a right shoulder diagnosis of frozen shoulder versus impingement syndrome. This is new shoulder pain and there does not appear to have been prior acupuncture treatment for the right shoulder. An initial trial of a maximum of 6 acupuncture sessions is supported. However, the current request does not specify the number of sessions, and this type of review cannot modify requests. Therefore, the request is not medically necessary.