

Case Number:	CM14-0020275		
Date Assigned:	02/21/2014	Date of Injury:	06/08/2010
Decision Date:	06/27/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/18/2014

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 Orthopedic Surgery, has a subspecialty in Spine Fellowship, 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:

The patient is a 46-year-old employee of the [REDACTED] with an injury related to repetitive duties. 1/22/14 progress report indicates bilateral carpal tunnel syndrome. Physical exam demonstrates positive Phalen's and positive Tinel's at the bilateral wrists. Discussion identifies that the patient wishes to proceed slowly with physical therapy, possible cortisone injections and, lastly, surgery if necessary. There is documentation of a previous 2/10/14 adverse determination; physical therapy was partially certified as guidelines allow up to three physical therapy sessions for carpal tunnel syndrome; non-certified drug sensitivity testing as guidelines do not support genetic testing for drug sensitivity; non-certified bilateral carpal tunnel decompression due to lack of failure of conservative treatment and lack of electrodiagnostic testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TO THE HAND/WRIST, #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Physical therapy Page(s): 98-99.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines support an initial course of physical therapy with objective functional deficits and functional goals. The patient presents with bilateral CTS. An initial course of PT was already certified in a 2/10/14 partial certification. Any additional sessions would require assessment of objective functional response to the initial trial. Therefore, the request is not medically necessary.

PAIN MANAGEMENT CONSULTATION: 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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page(s) 127, 156

Decision rationale: The guidelines state that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. However, the patient was just initiated on what appears to have been the initial course of treatment. There is no assessment of response to lower levels of care. There is no evidence that diagnostic and therapeutic management was exhausted within the treating provider's scope of practice. Therefore, the request was not medically necessary.

CYP-450 DRUG SENSITIVITY TEST: 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 Official Disability Guidelines (ODG) Pain Chapter, Genetic Testing

Decision rationale: CA MTUS does not apply. ODG states that genetic testing is not recommended. While there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. Studies are inconsistent, with inadequate statistics and large phenotype range. There is no evidence as to why a cytochrome P450 drug sensitivity test would be required in this patient. Recommend non-certification. The request is not medically necessary and appropriate.

CARPAL TUNNEL DECOMPRESSION, RIGHT: 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), Physical Medicine and Rehabilitation Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: CA 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, the most recent medical reports contained no comprehensive assessment of the patients subjective complaints. Neurologic testing was not documented. Electrodiagnostic studies were not performed. There is no evidence that attempts at conservative management have failed. There is no evidence of attempts at steroid injections. Lastly, the patient expressed the desire to proceed slowly with physical therapy, possible cortisone injections; and there is no indication that such attempts at conservative care were undertaken. Therefore, the request is not medically necessary.

CARPAL TUNNEL DECOMPRESSION, LEFT: 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), Physical Medicine and Rehabilitation Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

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