

<b>Case Number:</b>	CM14-0080518		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	01/02/2012
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 46-year-old individual was reportedly injured on January 2, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated August 6, 2014, indicated that there were ongoing complaints of left side of the neck and left shoulder pains. The physical examination noted a loss of cervical lordosis and a decrease in cervical spine range of motion. Sensation was intact and deep tendon reflexes were equal bilaterally. The lumbar spine examination noted a loss of lordosis and a decreased range of motion into extension. Heel and toe walking were normal and there was pain with facet loading. A cervical facet joint injection was completed. Diagnostic imaging studies objectified a cervical disc protrusion at C3-C4, C4-C5, and C5-C6. A radiculopathy was noted in the C6-C7 distribution. Previous treatment included contralateral carpal tunnel syndrome release, cubital tunnel release, multiple medications, physical therapy and pain management interventions. A request had been made for right carpal tunnel release, preoperative medical clearance H&P, preoperative CBC and CMP, preoperative EKG, preoperative chest x-ray, polar carse rental, sling, and medications and was not certified in the pre-authorization process on May 15, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT CARPAL TUNNEL RELEASE:** Upheld

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

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

**Decision rationale:** As outlined in the ACOEM guidelines, this type of surgery is reserved for electrodiagnostic studies illustrating a severe carpal tunnel syndrome. There is no clinical data presented to support a severe carpal tunnel syndrome. As such, there is insufficient clinical data presented to support the medical necessity of such a surgical intervention.

**PRE-OP MEDICAL CLEARANCE H&P:** 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-OP CBC AND CMP:** 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 OPERATE 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 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Preoperative Evaluation Am Fam Physician. 2000 Jul 15; 62(2):387-396.

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

**POLAR CARSE RENTAL FOR 21 DAYS:** 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.

**SLING:** 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.

**AMOCICILLIN 875 MG # 120:** 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.

**ZOFRAN 8 MG # 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.

**GABAPENTIN 60 MG # 90:** 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.

**ULTRACET 37.5/325 MG # 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**PROTONIX 20 MG # 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** This medication is useful for the treatment of gastroesophageal reflux disease. It can also be considered as a gastric protectant for individuals on non-steroidal medications. Given the diagnosis offered, there is no indication for non-steroidal medications. Furthermore, when considering the date of injury, there are no complaints of gastritis or gastroesophageal reflux disease. Furthermore, there are no objective symptomatology indicating gastrointestinal distress. As such, there is no clinical indication for this medication.

**NAPROXEN 550 MG # 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 and 73.

**Decision rationale:** This medication is indicated as an option to treat signs and symptoms of osteoarthritis. The carpal tunnel syndrome is not this malady. As such, a non-steroidal is not clinically indicated.