

<b>Case Number:</b>	CM15-0186294		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	07/14/2000
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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: California, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 65-year-old male, who sustained an industrial injury on 7-14-2000. Medical records indicate the worker is undergoing treatment for bilateral carpal tunnel syndrome per electromyography (EMG)-nerve conduction study (NCS) done 10-27-2014. A recent progress report dated 8-6-2015, reported the injured worker complained of increasing pain in the bilateral hands and forearms with the right hand worse than the left. Physical examination revealed marked atrophy of the thenar muscles in the bilateral hands and thenar muscle weakness of both hands. There was a positive Tinel's sign and Phalen's testing bilaterally with all of the finding for carpal tunnel entrapment. Treatment to date has included physical therapy and medication management. On 8-7-2015, the Request for Authorization requested Tenolysis of flexor tendon right wrist and hand; fasciotomy distal antebrachial fascia right wrist; exploration with epineurolysis median nerve right wrist, medical clearance, chest x ray, CBC, PT-PTT, Chemistry 12, urinalysis, compression stocking, deep vein thrombosis compression pump, smart glove for the right hand, Micro cool, Interferential therapy unit, right wrist brace, home exercise kit, 12 sessions of acupuncture, 12 sessions of physical therapy, Keflex 500mg #20, Tramadol HCL 50mg #60 and Norco 10-325mg #60. On 8-19-2015, the Utilization Review noncertified the request for Tenolysis of flexor tendon right wrist and hand; fasciotomy distal antebrachial fascia right wrist; exploration with epineurolysis median nerve right wrist, medical clearance, chest x ray, CBC, PT-PTT, Chemistry 12, urinalysis, compression stocking, deep vein thrombosis compression pump, smart glove for the right hand, Micro cool, Interferential therapy

unit, right wrist brace, home exercise kit, 12 sessions of acupuncture, 12 sessions of physical therapy, Keflex 500mg #20, Tramadol HCL 50mg #60 and Norco 10-325mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tenolysis of flexor tendon right wrist and hand; fasciotomy distal antebrachial fascia right wrist; exploration with epineurolysis median nerve right wrist:** 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), Forearm, Wrist and Hand Chapter-Tenolysis, Diagnostic Arthroscopy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist Chapter.

**Decision rationale:** CA MTUS/ACOEM do not specifically address neurolysis. According to ODG, Carpal Tunnel syndrome, Carpal Tunnel Release Surgery, Adjunctive procedures: The 2008 AAOS CTS clinical treatment guidelines concluded that surgeons not routinely use the following procedures when performing carpal tunnel release: Skin nerve preservation; & Epineurotomy. The following procedures had no recommendation for or against their use: Flexor retinaculum lengthening; Internal neurolysis; Tenosynovectomy; & Ulnar bursa preservation. Therefore, neurolysis and tenosynovectomy is not recommended and the combined request by the treating physician is not medically necessary.

**Associated Surgical Service: Medical clearance:** 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.

**Associated Surgical Service: 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 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.

**Associated Surgical Service: CBC:** 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.

**Associated Surgical Service: PT/PTT:** 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.

**Associated Surgical Service: Chem 12:** 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.

**Associated Surgical Service: UA:** 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.

**Associated Surgical Service: Compression stocking:** 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.

**Associated Surgical Service: DVT compression pump:** 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.

**Associated Surgical Service: Smart glove for the right hand:** 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.

**Associated Surgical Service: Micro Cool:** 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.

**Associated Surgical Service: Interferential current therapy (IFC) unit:** 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.

**Associated Surgical Service: Right wrist brace:** 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.

**Associated Surgical Service: Home exercise kit:** 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.

**Associated Surgical Service: Twelve sessions of acupuncture (2x6):** 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.

**Associated Surgical Service: Twelve sessions of physical therapy (2x6):** 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.

**Keflex cap 500mg #20, 1 cap four times a day for five days:** Upheld

**Claims Administrator guideline:** Decision not based on MTUS. Decision based on Non-MTUS Drugs.com.

**MAXIMUS guideline:** Decision not based on MTUS. Decision based on Non-MTUS American Family Physician Journal, 2002 July 1; 66 (1): 119-125, Common bacterial skin infections.

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

**Tramadol HCL 50mg #60, 1 tab q4-6 hr as needed for pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Opioids for chronic pain.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore use of Tramadol is not medically necessary.

**Norco tab 10/325mg #60, 1 tab q4-6 hr as needed for breakthrough pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Opioids for chronic pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore, the request is not medically necessary.