

<b>Case Number:</b>	CM15-0200269		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	01/13/2012
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine

### 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 35 year old female sustained an industrial injury on 1-13-12. Documentation indicated that the injured worker was receiving treatment for right ulnar neuropathy, right carpal tunnel syndrome, right De Quervain's syndrome and left cubital tunnel syndrome. Previous treatment included occupational therapy, bracing, injection and medications. Electromyography and nerve conduction velocity test of bilateral upper extremities (6-26-15) showed mild bilateral carpal tunnel syndrome and bilateral ulnar neuropathy consistent with bilateral Guyon's canal entrapment of a mild nature as well as bilateral chronic cervical spine radiculopathy. In a PR-2 dated 8-11-15, the injured worker complained of bilateral hand burning, tingling and numbness with tingling of all fingers and shooting pain from the fingers to the inner aspect of both elbows. Physical exam was remarkable for positive left median nerve compression test, positive Tinel's and Phalen's sign at the left carpal tunnel, positive ulnar nerve compression test at the left Guyon's canal and slight tenderness at the left thenar eminence. The physician stated that the injured worker's symptom's had worsened despite conservative care. The physician recommended left carpal tunnel release and release of the left ulnar nerve with associated surgical services. On 9-19-15, Utilization Review noncertified a request for left carpal tunnel release and ulnar nerve release Guyon - left neuroplasty median nerve carpal tunnel, left wrist flexor tenosynovectomy, advancement tissue rearrangement hand, neuroplasty ulnar nerve, a wrist guyon canal and inh anesthetic peripheral nerve, brevis medial nerve (left) with associated surgical services.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left carpal tunnel release and ulnar n. rel Guyon - left neuroplasty median n carpal tunnel -left wrist flexor tenosynovectomy - advancement tissue rearrangement hand (left) - neuroplasty ulnar n. a wrist guyon canal (left) - inh anesthetic peripheral nerve/br medial n (left): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic), Carpal tunnel release surgery (CTR).

**Decision rationale:** As per MTUS, Referral for hand surgery consultation may be indicated for patients who:- Have red flags of a serious nature- Fail to respond to conservative management, including worksite modifications- Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan. As per Official Disability Guidelines (ODG), Carpal tunnel release surgery (CTR) is recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS, unless symptoms persist after conservative treatment. See Severity definitions. Carpal tunnel release is well supported, both open and endoscopic (with proper surgeon training), assuming the diagnosis of CTS is correct. (Unfortunately, many CTR surgeries are performed on patients without a correct diagnosis of CTS, and these surgeries do not have successful outcomes.) Outcomes in workers' comp cases may not be as good as outcomes overall, but studies still support the benefits from surgery. Carpal tunnel syndrome may be treated initially with education, activity modification, medications and night splints before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits), but outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Surgical decompression of the median nerve usually has a high rate of long-term success in relieving symptoms, with many studies showing success in over 90% of patients where the diagnosis of CTS has been confirmed by electrodiagnostic testing. (Patients with the mildest symptoms display the poorest post-surgery results, but in patients with moderate or severe CTS, the outcomes from surgery are better than splinting.) Carpal tunnel syndrome should be confirmed by positive findings on clinical examination and may be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or

severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. Any contributions to symptoms by cervical radiculopathy (double crush syndrome) will not be relieved by the surgery. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. No clear documentation of failed conservative measures, if any can be located within the submitted medical records. Electrodiagnostic studies are noted to be normal. Review of submitted medical records of injured worker lack clinical data that satisfies these guidelines, therefore medical necessity of the requested item has not been established.

**Associate service: applicant short arm splint (left) (inclusive of pre-op clearance): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

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

**Post- operative occupational therapy 3x4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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

**Associate service: Cold pneumatic compression therapy unit 30 day rental: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

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

**Associate service: (CPM) continuous passive motion device for hand/finger movement: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hand Wrist.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Continuous passive motion (CPM).

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

**Associate service: (DVT) deep vein thrombosis device:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder Online.

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

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

**Associate service: electrical stimulation device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

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

**Cephalexin (keflex) 500mg, 1 tab by mouth every 6 hours x7 days #30, 0refill:** 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) Infectious Diseases -Cephalexin (Keflex).

**Decision rationale:** As per ODG Keflex is recommended as first-line treatment for cellulitis and other conditions. For outpatients with non-purulent cellulitis, empirical treatment for infection

due to beta-hemolytic streptococci and methicillin-sensitive *S. aureus*, cephalexin 500 mg QID is recommended, as well for penicillin allergic that can tolerate cephalosporins. Routine use of postop antibiotic treatment is not recommended. As the requested treatment: Left carpal tunnel release and ulnar n. rel Guyon; left neuroplasty median n carpal tunnel; left wrist flexor tenosynovectomy; advancement tissue rearrangement hand (left); neuroplasty ulnar n. a wrist guyon canal (left); inh anesthetic peripheral nerve/br medial n (left) is determined not medically necessary, the medical necessity of Cephalexin (keflex) 500mg, 1 tab by mouth every 6 hours x7 days #30, has not been established.

**Ondansetron ODT (Zofran) 4mg 1 tablet by mouth every day PK/30, 0 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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, Antiemetics.

**Decision rationale:** ODG Pain Chapter: Antiemetics (for opioid nausea) Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. As the requested treatment: Left carpal tunnel release and ulnar n. rel Guyon; left neuroplasty median n carpal tunnel; left wrist flexor tenosynovectomy; advancement tissue rearrangement hand (left); neuroplasty ulnar n. a wrist guyon canal (left); inh anesthetic peripheral nerve/br medial n (left) is determined not medically necessary, the medical necessity of Ondansetron ODT (Zofran) 4mg 1 tablet by mouth every day PK/30 has not been established.

**Tylenol #4, 1 tablet by mouth every 4-6 hours as need for pain #90, 0 refill: Upheld**

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

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

**Decision rationale:** Tylenol with Codeine is a short-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. It is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance, but codeine with acetaminophen is a C-III controlled substance. As the requested treatment: Left carpal tunnel release and ulnar n. rel Guyon; left neuroplasty median n carpal tunnel; left wrist flexor tenosynovectomy; advancement tissue rearrangement hand (left); neuroplasty ulnar n. a wrist guyon canal (left); inh anesthetic peripheral nerve/br medial n (left) is determined not medically necessary, the medical necessity of Tylenol #4, 1 tablet by mouth every 4-6 hours as need for pain #90, has not been established.

**Wound care cream (Fluticasone 1%, Levocetirizine 2%, Pentoxifylline 0.05%, Prilocaine 3%, Gabapentin 15%), apply 1-3 gm to affected area 3-4 times daily 91pump-1gm) quantity 150gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. As the requested treatment: Left carpal tunnel release and ulnar n. rel Guyon; left neuroplasty median n carpal tunnel; left wrist flexor tenosynovectomy; advancement tissue rearrangement hand (left); neuroplasty ulnar n. a wrist guyon canal (left); inh anesthetic peripheral nerve/br medial n (left) is determined not medically necessary, the medical necessity of Wound care cream has not been established.