

Case Number:	CM15-0221889		
Date Assigned:	11/17/2015	Date of Injury:	11/23/2012
Decision Date:	12/31/2015	UR Denial Date:	11/04/2015
Priority:	Standard	Application Received:	11/11/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59 year old male, who sustained an industrial injury on 11-23-2012. A review of the medical records indicates that the worker is undergoing treatment for left carpal tunnel release, left ulnar transposition, right carpal tunnel syndrome and depression, anxiety and insomnia. A left carpal tunnel release was noted to have been performed in 2014 without success. Electromyography-nerve conduction study on 03-02-2015 showed no evidence of neuropathy, plexopathy or radiculopathy of the left upper extremity. Treatment has included Naproxen, Topamax, Nortriptyline, physical therapy, home exercise program, transcutaneous electrical nerve stimulator unit, surgery and splinting. Subjective complaints (04-20-2015) included left elbow pain ranging from 3-9 out of 10 and objective findings showed decreased sensation along the left ulnar aspect of the forearm, positive Tinel's test of the elbow and positive Tinel's at the wrist bilaterally. Subjective complaints (06-22-2015) included left elbow pain rated as 4 to 10 and had increased. Objective findings showed weakness in his grip and significantly positive Tinel's sign on the left. Subjective complaints (10-26-2015) included bilateral hand and left elbow pain that varied from a 2 to a 10. Objective findings (10-26-2015) included tenderness to palpation of the cubital tunnel and positive Tinel's sign of the left wrist. The physician noted that a request for left median nerve injection under anesthesia was being made as well as a request for functional restoration program. The rationale for the requests was not given. There was no documentation of any prior median nerve injections. There was no documentation of baseline function clearly noted. A utilization review dated 11-04-2015 non-certified a request for

left carpal tunnel (median nerve) injection, ultrasound (for median nerve injection) and functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Carpal Tunnel (median nerve) injection: 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 ODG, Wrist and Hand, Injections.

Decision rationale: The patient presents with pain affecting the bilateral hand and left elbow. The current request is for Left Carpal Tunnel (median nerve) injection. The treating physician report dated 10/26/15 (58B) states, "I would like to request for the left median nerve injection to be done under ultrasound." The MTUS guidelines do not address the current request. The ODG guidelines states the following regarding injection of the forearm, wrist and hand: Recommended for Trigger finger and for de Quervain's tenosynovitis as indicated below. In this case, there is no evidence that the patient presents with Trigger finger or de Quervain's tenosynovitis. The current request is not medically necessary.

Ultrasound (for median nerve injection): 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 ODG, Wrist and Hand, Injections.

Decision rationale: The patient presents with pain affecting the bilateral hand and left elbow. The current request is for Ultrasound (for median nerve injection). The treating physician report dated 10/26/15 (58B) states, "I would like to request for the left median nerve injection to be done under ultrasound." The MTUS guidelines do not address the current request. The ODG guidelines states the following regarding injection of the forearm, wrist and hand: Recommended for Trigger finger and for de Quervain's tenosynovitis as indicated below. In this case, there is no evidence that the patient presents with Trigger finger or de Quervain's tenosynovitis. In this case, since the request for an injection is not medically necessary, the current request for ultrasound is not medically necessary.

Functional Restoration Program: 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): Functional restoration programs (FRPs).

Decision rationale: The patient presents with pain affecting the bilateral hand and left elbow. The current request is for Functional Restoration Program. The treating physician report dated 10/26/15 (58B) provides no rationale for the current request. The MTUS guidelines recommend functional restoration programs when certain criteria is met. The guidelines go on to state the following regarding the Criteria for the general use of multidisciplinary pain management programs: Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved. In this case, while the patient might be a candidate for a program that can restore function, the current request does not specify a quantity of hours in which the patient would participate in such a program, and the MTUS guidelines only support 20 full day sessions. Additionally the MTUS guidelines do not support an open ended request. Furthermore, there was no discussion in the documents provided as to what the Functional Restoration Program would entail and why it is necessary to the patient's rehabilitation. The current request is not medical necessary.