

Case Number:	CM14-0137801		
Date Assigned:	09/05/2014	Date of Injury:	01/03/2014
Decision Date:	10/27/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/26/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 injured worker is a 50 year old female who sustained an injury on 01/03/14 due to repetitive activities at her occupation. The injured worker has been followed for bilateral upper extremities pain at the hand and wrist more severe to the left than the right. Electrodiagnostic studies completed on 04/08/14 noted severe left sided carpal tunnel syndrome. The injured worker was initially provided muscle relaxers. As of 07/09/14 the injured worker continued to report low back pain as well as pain in the bilateral elbows. The physical exam findings were not specific regarding any physical exam findings at the left wrist consistent with carpal tunnel syndrome. This was partially due a handwritten report that was difficult to interpret due to handwriting and copy quality. There did appear to the bilateral Tinel's sigs; however, it is unclear where the location was. There was reported loss of sensation in the left median nerve distribution; however, no 2-point discrimination findings or monofilament testing was apparent. The requested MRI LUMBAR SPINE QTY: 1.00, LEFT CARPAL TUNNEL RELEASE WITH POSSIBLE FLEXO; TENOSYNOVECTOMY AND/OR MEDIAN NEUROLYSIS QTY: 1.00, PRE-OPERATIVE CLEARANCE QTY: 1.00, POST OPERATIVE PHYSICAL THERAPY QTY: 8.00, POST OPERATIVE COLD THERAPY UNIT QTY: 1.00, RIGHT WRIST CARPEL TUNNEL INJECTION UNDER ULTRASOUND GUIDANCE QTY: 1.00, and REVIEW OF MEDICAL RECORDS TO BE COMPENSATED FOR A NARRATIVE REPORT QTY: 1.00 were all denied on 07/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR SPINE QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: In review of the clinical documentation provided, there was no clear objective evidence of any progressive or severe neurological deficits as well as any indications that the injured worker had completed a course of conservative treatment to include physical therapy that would support MRI studies of the lumbar spine as recommended by current evidence based guidelines. As such, this reviewer would not have recommended this request as medically necessary.

**LEFT CARPAL TUNNEL RELEASE WITH POSSIBLE FLEXO;
TENOSYNOVECTOMY AND/OR MEDIAN NEUROLYSIS QTY: 1.00: Upheld**

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 279-280.

Decision rationale: The surgical request for the left upper extremity is not indicated as medically necessary. The injured worker's EMG/NCS studies were notable for evidence regarding severe carpal tunnel syndrome; however, the documentation regarding non-operative treatment was limited and the injured worker's physical exam findings were not specific regarding findings for left sided carpal tunnel syndrome to include abnormal sensory findings or evidence of atrophy as recommended by current evidence based guidelines. As such, the surgical request was not indicated as medically appropriate.

PRE-OPERATIVE CLEARANCE QTY: 1.00: 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-TWC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

Decision rationale: As the surgical request for this injured worker was not indicated, there would be no requirement for the requested services. As such, medical necessity is not established.

POST OPERATIVE PHYSICAL THERAPY QTY: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, general.

Decision rationale: As the surgical request for this injured worker was not indicated, there would be no requirement for the requested services. As such, medical necessity is not established.

POST OPERATIVE COLD THERAPY UNIT QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

Decision rationale: As the surgical request for this injured worker was not indicated, there would be no requirement for the requested services. As such, medical necessity is not established.

RIGHT WRIST CARPEL TUNNEL INJECTION UNDER ULTRASOUND GUIDANCE QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 276.

Decision rationale: The requested right carpal tunnel injection would not be indicated as medically necessary. The NCS findings were negative for evidence of a right carpal tunnel syndrome and the most recent physical exam findings were not discernable for any clear findings consistent with carpal tunnel syndrome to support the request. As such, this reviewer would not have recommended this request as medically appropriate.

REVIEW OF MEDICAL RECORDS TO BE COMPENSATED FOR A NARRATIVE REPORT QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Current Medical Diagnosis and Treatment, 2012. Goroll A.H. Primary Care Medicine, 7th ed. ISBN/ISSN: 9781451151497.

Decision rationale: This request would not be supported as medically necessary. There was no specific rationale provided for this request. Therefore this reviewer would not have recommended this request as medically appropriate.