

<b>Case Number:</b>	CM14-0163663		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	11/16/2012
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Orthopedic Surgery 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:

65-year-old injured worker with reported industrial injury on November 16, 2012. Diagnosis is noted of right shoulder tendinitis, right carpal tunnel syndrome, radial collateral ligament tear the right elbow with left medial epicondylitis with right ulnar nerve entrapment cubital tunnel. Associated diagnoses include left carpal tunnel syndrome and left cubital tunnel syndrome. Electrodiagnostic studies performed on April 23, 2014 demonstrate severe carpal tunnel syndrome left greater than right. Exam note from May 6, 2014 demonstrates positive Tinel's and Phalen's sign, with pain in the forearm and tenderness in both elbows on the medial side. Exam note September 29, 2014 demonstrates left knee pain graded as 7 out of 10. Patient reports heightened function with medication at current dosing with examples provided in the records. Examination demonstrates tenderness in the left knee. There is positive patellofemoral compression test noted. Crepitus with range of motion is also noted. The patient is noted to lack 5 of extension and 90 of flexion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Knee Arthroscopy:** 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:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Meniscectomy

**Decision rationale:** CAMTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear--symptoms other than simply pain (locking, popping, giving way, recurrent effusion). According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case the exam notes from 9/29/14 do not demonstrate evidence of adequate course of physical therapy or other conservative measures. In addition there is lack of evidence in the cited records of meniscal symptoms such as locking, popping, giving way or recurrent effusion. In addition there is no MRI formal report. Therefore the request is not medically necessary

**Acupuncture, 2 x week for 6 weeks for the Lumbar Spine, Bilateral Knees, Right Shoulder, Right Elbow, and Right Wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8 & 9, Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:(1) Time to produce functional improvement: 3 to 6 treatments, (2) Frequency: 1 to 3 times per week, (3) Optimum duration: 1 to 2 months, (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). The guidelines specifically report 3-6 treatments initially. As the request is for 12 visits the request is not medically necessary.

**Associated surgery service: Pre-Op medical Clearance with labs, 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.

**Associated surgery service: 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.

**Associated surgery service: Post- Op Physical Therapy, 3 times a week for 4 weeks for the Left Knee:** 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 surgery service: Tramadol 150mg, #120:** 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 Tramadol Page(s): 93-94.

**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 9/29/14 of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore the request for Tramadol is not medically necessary.

**Associated surgery service: Cyclobenzaprine 7.5mg, #90:** 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): 41-42.

**Decision rationale:** According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case the patient has no evidence in the records of 9/29/14 of

functional improvement, a quantitative assessment on how this medication helps percentage of relief lasts, increase in function, or increase in activity. Therefore chronic usage is not supported by the guidelines. Therefore the request is not medically necessary.