

<b>Case Number:</b>	CM15-0002134		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	08/09/1999
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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: Illinois, California, Texas  
 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 53-year-old female who sustained an industrial related injury on 8/9/99, due to cumulative trauma. She underwent right carpal tunnel release in 1996 and left carpal tunnel release in 1997. Carpal tunnel syndrome returned in 1998. She reported an onset of right shoulder pain. The 3/27/10 right shoulder MRI documented mild supraspinatus tendinosis with possible partial thickness undersurface tear. The 11/6/13 electrodiagnostic study showed bilateral moderate compression of the median nerve at the carpal tunnel versus normal post-surgical changes. There was no evidence of cervical radiculopathy. The 11/19/14 Doctor's First Report documented complaints of constant bilateral hand pain radiating to the shoulder and constant right shoulder pain. Hand symptoms included tingling up the arm and numbness in digits 1-4 bilaterally. Upper extremity symptoms increased with activities of daily living, lifting, pulling, pushing, gripping, and overhead reaching. Neck pain radiated to both shoulders and increased with repetitive cervical motion. Additional complaints were noted in both elbows, left shoulder, neck, and upper back. Wrist exam documented bilateral thenar wasting, joint tenderness, normal range of motion, and 4/5 forearm flexor/extensor and interossei muscle strength bilaterally. There was decreased sensation over the radial three fingers bilaterally, two-point discrimination 5-6 mm, positive Phalen's bilaterally, inability to make a complete fist, and symmetrical grip. Shoulder exam documented global tenderness, 4/5 supraspinatus and deltoid weakness, and positive impingement tests. Shoulder range of motion (right/left) was: flexion 120/130, abduction 115/125, adduction 20/30, extension 30/40, internal rotation 60/70, and external rotation 65/70 degrees. Cervical exam documented muscle spasms, paraspinal tenderness,

negative axial compression test, and loss of range of motion with crepitation. Bilateral wrist x-rays documented arthrosis. Cervical x-rays documented narrowing at C4/5 and C5/6. Right shoulder x-rays showed evidence of anterior acromionectomy, with small subacromial osteophyte formation, irregularity of the greater tuberosity, and acromioclavicular joint osteoarthritis. The diagnosis included cervical strain with spondylosis and degenerative disease, right shoulder impingement with rotator cuff tear, and recurrent carpal tunnel syndrome. The treating physician requested authorization for bilateral carpal tunnel release re-do surgery with neurolysis of the median nerve, post-operative physical therapy for the right shoulder x12, DME sling, right shoulder arthroscopic examination surgical repair of the cuff as necessary, medical clearance, ultra-sling, cold therapy unit, post-operative physical therapy x12, assistant surgeon, Zantac 150mg #60, MRI of the cervical spine, and post-operative physical therapy for bilateral wrists x12. On 12/4/14, the requests were non-certified. Regarding the carpal tunnel release and shoulder arthroscopy, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted the request was non-certified as there was no documentation of recent conservative treatment. Due to the surgical procedures being non-certified the associated surgical services were also non-certified. Regarding Zantac, the UR physician cited the MTUS guidelines and noted the request was non-certified as there was no documentation of high risk gastrointestinal complications secondary to NSAID use. Regarding the cervical MRI, the UR physician cited the MTUS guidelines and noted the request was non-certified as there was no recent documentation of radicular symptoms/findings. The 12/4/14 utilization review certified requests for bilateral shoulder corticosteroid injections and Motrin 600 mg #60.

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

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

**Bilateral carpal tunnel release re-do surgery along with neurolysis of the median nerve:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Carpal tunnel syndrome, Carpal tunnel release surgery (CTR)

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. The Official Disability Guidelines provide clinical indications for carpal tunnel release that include specific symptoms (abnormal Katz hand diagram scores, nocturnal symptoms, and/or Flick Sign), physical exam findings (compression test, monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, and/or mild thenar weakness), conservative treatment (activity modification, night wrist splint, non-prescription analgesia, home exercise training), successful corticosteroid injection trial, and positive electrodiagnostic testing. Guideline criteria have not been met. This patient presents

with a history of recurrent carpal tunnel syndrome. Electrodiagnostic studies in 2013 were equivocal. Clinical exam findings were consistent with carpal tunnel syndrome. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

**Arthroscopic examination, SX repair of the cuff as necessary:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome/rotator cuff repair that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. This patient has bilateral shoulder pain with functional difficulty in overhead reaching. Clinical findings are consistent with imaging evidence of a possible partial thickness rotator cuff tear. Records indicate that a corticosteroid injection was approved. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary at this time.

**Post-op physical therapy 12 visits, right shoulder:** 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.

**Sling:** 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.

**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 base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

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

**Ultra sling:** 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 Shoulder, Postoperative abduction pillow sling

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

**Cold therapy unit:** 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 Shoulder: Continuous flow cryotherapy

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

**Post-op physical therapy;twelve (12)sessions:** 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 Carpal tunnel syndrome Shoulder Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

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

**Assistant surgeon:** 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 Centers for Medicare and Medicaid services Physician Fee Schedule Assistant Surgeons <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

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

**Zantac 150mg #60;one tab po BID:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The California MTUS guidelines provide specific criteria for patients at risk for gastrointestinal events taking non-steroidal anti-inflammatory drugs (NSAIDs). Risk factors include age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). For treatment of dyspepsia secondary to NSAID therapy, guidelines recommend stopping the NSAID, switching to a different NSAIDs, or consideration of an H2 receptor antagonist, like Zantac, or a proton pump inhibitor. Guideline criteria for intermediate gastrointestinal risk factors have not been met. The patient has been prescribed a low dose NSAID. There is no documentation that this patient has previously experienced dyspepsia with the use of NSAIDs to support the addition of an H2 receptor antagonist at this time. Therefore, this request is not medically necessary.

**MRI for the cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Neck and Upper Back: MRI?s (magnetic resonance imaging)

**Decision rationale:** The California MTUS guidelines provide criteria for ordering cervical spine MRIs that includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Guideline criteria have not been met. There is no current physiologic evidence of severe or progressive tissue insult or focal neurologic dysfunction. There is no indication of significant change in symptoms and/or findings suggestive of significant pathology to support the medical necessity of repeat MRI. Therefore, this request for MRI of the cervical spine is not medically necessary.

**Post-op physical therapy; twelve(12)visits for the bilateral wrists:** 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.