

<b>Case Number:</b>	CM15-0002789		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	05/07/2003
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	12/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports 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:

The injured worker is a 53-year-old male who reported an injury on 05/07/2003. The mechanism of injury was not specifically stated. The current diagnoses include displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, and bilateral knee osteoarthritis. The injured worker presented on 11/10/2014 for an evaluation with complaints of right shoulder pain, right wrist pain, bilateral knee pain, and insomnia. Upon examination of the right wrist, there was normal range of motion with positive Tinel's and Phalen's signs. Examination of the left knee revealed patellofemoral crepitus with 0 to 120 degrees range of motion. There was 5/5 motor strength in the bilateral upper extremities with 2+ deep tendon reflexes. Recommendations at that time included a right carpal tunnel release and a left total knee arthroplasty. A Request for Authorization form was then submitted on 11/10/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Carpal Tunnel Release:** 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): s 270-271.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a 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 work site modification), and have clear clinical and special study evidence of a lesion. Carpal tunnel syndrome must be proved by positive findings on clinical examination and supported by nerve conduction studies. While it was noted that the injured worker had positive Tinel's and Phalen's signs upon examination, there was no evidence of carpal tunnel syndrome. There was no documentation of a 2-point discrimination. There was also no evidence of median neuropathy. There were no official electrodiagnostic studies provided for this review. There was also no mention of a recent attempt at any conservative management to include work site modification. Given the above, the request is not medically appropriate.

**Flurbi (20%), Cyclo (4%), Lido (5%), 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), National Guideline Clearinghouse and PubMed.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is Diclofenac. The request for a compounded cream containing flurbiprofen would not be supported. Muscle relaxants are not recommended for topical use. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Norco 10/325mg, #80:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, it is noted that the injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional

improvement despite the ongoing use of Norco 10/325 mg. In addition, the frequency was not provided in the request. Given the above, the request is not medically appropriate.

**MRI of the Left Knee:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): s 341-343.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. In this case, it is noted that the injured worker underwent a prior left knee MRI on 11/12/2012. There is no documentation of any significant changes in physical examination. There is no evidence of the emergence of any red flags. The medical necessity for a repeat MRI has not been established in this case. As such, the request is not medically appropriate at this time.

**MRI of the Lumbar Spine:** 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 12 Low Back Complaints  
Page(s): s 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there was no evidence of a significant change or worsening of symptoms or examination findings to support the necessity for a repeat imaging study. The injured worker underwent a prior lumbar spine MRI on 02/16/2013. As the medical necessity has not been established, the request is not medically appropriate at this time.

**Total Left Knee Replacement:** 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): s 343-345.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule, a referral for a surgical consultation may be indicated for patients who have activity limitations for more than 1 month and a failure of exercise programs. In this case, there was no documentation of a significant functional limitation upon examination. There were no official imaging studies or x-ray reports documented. Additionally, there was no mention of a recent attempt at any

conservative management for the left knee prior to the request for a total knee replacement. Given the above, the request is not medically appropriate.

**Pre-Operative Medical Clearance (labs, chest, x-ray, 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.

**Post-Operative Home Health Aide (3-hours per day for 5-days per week for 3-weeks to include a RV evaluation and administration of Lovenox SQ daily for 14 days, wound cleaning, bandage cleaning, bathing, and light cleaning): 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.

**Post-Operative Physical Therapy (18 home based sessions): 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.

**Post-Operative Physical Therapy (8- sessions for the right hand): 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.

**Post-Operative Knee Brace: 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.

**Post-Operative Walker:** 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.

**Post-Operative 3-in-1 Commode:** 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.

**Post-Operative Picker:** 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.

**Post-Operative Sock Aide:** 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.