

<b>Case Number:</b>	CM15-0112540		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	05/31/2002
<b>Decision Date:</b>	09/28/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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, Indiana, Oregon  
 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 54 year old male with an industrial injury dated 05/31/2002. The injured worker's diagnoses include status post right hand crush injury, status post right wrist surgery, right lunotriquetral instability, right ulnar nerve palsy, right little finger metacarpal-5 joint extension contracture, right carpal tunnel syndrome, right little finger tendonitis A-1 pulley without triggering, Right de Quervain's disease status post, status post right metacarpal-5 hardware rem, status post right EDC-5 & EDM ext teno, capsulotomy metacarpal-5, release abductor on 6/15/2005, status post right 4- portal wrist arthroscopy, synovectomy, debridement on 6/14/2006, status post right total wrist arthroplasty on 10/25/2006, right flexor carpi ulnaris (FCR) tendonitis, right radial wrist chronic pain, status post right first and second dorsal comp rel, ext tenosynovectomy on 10/22/2008 and right lateral epicondylitis. Treatment consisted of diagnostic studies, prescribed medications, cortisone injections and periodic follow up visits. In a progress note dated 05/21/2015, the injured worker reported swelling in the right hand, increasing pain in right wrist and increasing pain while making a fist/right hand. Objective findings revealed pain in volar aspect of right hand, positive Tinel's sign overlying scar and palm and soft tissue mass flexor tenosynovitis of right side. The treating physician prescribed services for Neuroplasty of median nerve at carpal tunnel wrist flexor tenosynovectomy, advancement tissue rearrangement hand, neuroplasty (digital, ulnar nerve at the hand and wrist, median nerve) with general IV sedation and injection of anesthetic peripheral nerve, Labs: CBC + Diff, Labs: PL, SMA-7, Labs: PT/PTT, Urinalysis, EKG, Chest X-ray, Preoperative History & Physical, Postoperative Occupational Therapy QTY: 12, Custom short arm splint, wrist neutral and its

application QTY: 1, Cold pneumatic compression therapy unit 30 days, Continuous Passive Motion (CPM) Device (frequency & duration unspecified), DVT Device (frequency & duration unspecified), Interferential Stimulation Unit ((frequency & duration unspecified), Cephalexin 500mg #30, Diclofenac Sodium ER 100mg #30 with 1 refill, Cyclobenzaprine 7.5mg #90 with 1 refill, Pantoprazole Sodium 20mg #30 with 1 refill, Tylenol #4 quantity: 90 with 1 refill, DNA Test panel, DNA pharmacogenomics diagnostic testing, Ondansetron 4mg with 1 refill (quantity unspecified), Would Care Cream (unspecified), and Urine Drug Screen now under review.

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

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

**Neuroplasty of median nerve at carpal tunnel wrist flexor tenosynovectomy, advancement tissue rearrangement hand, neuroplasty (digital, ulnar nerve at the hand and wrist, median nerve) with general IV sedation and injection of anesthetic peripheral nerve: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel.

**Decision rationale:** CA MTUS/ACOEM do not specifically address neurolysis. According to ODG, Carpal Tunnel syndrome, Carpal Tunnel Release Surgery, Adjunctive procedures: The 2008 AAOS CTS clinical treatment guidelines concluded that surgeons not routinely use the following procedures when performing carpal tunnel release: Skin nerve preservation; & Epineurotomy. The following procedures had no recommendation for or against their use: Flexor retinaculum lengthening; Internal neurolysis; Tenosynovectomy; & Ulnar bursa preservation. Therefore, neurolysis and tenosynovectomy is not recommended and the combined request by the treating physician is not medically necessary.

**Labs: CBC + Diff: 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.

**Labs: PL, SMA-7: 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.

**Labs: PT/PTT:** 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.

**Urinalysis:** 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.

**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.

**Chest X-ray:** 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.

**Preoperative History & Physical:** 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.

**Postoperative Occupational Therapy QTY: 12.00: 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.

**Custom short arm splint, wrist neutral and its application QTY: 1: 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.

**Cold pneumatic compression therapy unit 30 days: 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.

**Continuous Passive Motion (CPM) Device (frequency & duration unspecified): 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.

**DVT Device (frequency & duration unspecified):** 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.

**Interferential Stimulation Unit ((frequency & duration unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current Page(s): 118.

**Decision rationale:** Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." The request is for a device not recommended by the guidelines. The request is not medically necessary.

**Cephalexin 500mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Retrieved Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am Fam Physician. 2002 Jul 1; 66(1): 119-24.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on the issue of Keflex and alternative guideline were utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119/125, titled "Common Bacterial Skin Infections", Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

