

Case Number:	CM15-0127669		
Date Assigned:	07/14/2015	Date of Injury:	01/04/2002
Decision Date:	08/13/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	07/01/2015

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:

This 57 year old male sustained an industrial injury to the back, knees, feet, wrists, and hands on 10/15/12. Electromyography (2013) showed S1 radiculopathy. Previous treatment included left knee arthroscopy (1/2014), right carpal tunnel release (11/2013), physical therapy, injections, and medications. In the most recent documentation submitted for review, a follow up evaluation dated 3/13/15, the injured worker complained of persistent wrist pain associated with numbness and tingling. Physical exam was remarkable for tenderness to palpation across the lumbar spine paraspinal musculature bilaterally, pain along the facets and pain with facet loading. The injured worker walked using a cane with a slightly antalgic and wide-based gait. Current diagnoses included bilateral carpal tunnel syndrome, discogenic lumbar condition, internal derangement, right knee sprain and bilateral plantar fasciitis. The physician noted that nerve studies had not been done yet for bilateral upper extremities. The treatment plan included bilateral upper extremity electromyography/nerve conduction velocity test, a referral for pain management and requesting authorization for medications (Norco, Flexeril, Tramadol, LidoPro lotion, and Gabapentin).

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpal tunnel release surgery: 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 rationale: Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints page 270, Electrodiagnostic testing is required to evaluate for carpal tunnel and stratify success in carpal tunnel release. In addition, the guidelines recommend splinting and medications as well as a cortisone injection to help facilitate diagnosis. In this case there is lack of evidence in the records from 3/13/15 of electrodiagnostic evidence of carpal tunnel syndrome and a lack of evidence of failed bracing or injections. Therefore the request is not medically necessary.

Associated surgical services: Four (4) lead TENS unit for the low back for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation unit).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): s 113-114.

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 3/13/15 to warrant a TENS unit. The request is not medically necessary.

Associated surgical services: X-ray A/P lateral bilateral knees: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Complaints, Special Studies and Diagnostic and Treatment Considerations.

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

Decision rationale: CA MTUS, knee complaints page 341 indicates radiographs for a history of trauma or direct tenderness over the fibular head. In this case the note of 3/13/15 does not satisfy the guidelines. The request is not medically necessary.

Associated surgical services: Hyalgan injection series of five (5) for the right 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, Knee & Leg, Hyaluronic Acid Injections.

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

Decision rationale: CA MTUS/ACOEM is silent regarding the request for viscosupplementation for the knee. According to the ODG Knee and leg chapter, Hyaluronic acid injection, it is indicated for patients with documented severe osteoarthritis of the knee and patients who have failed 3 months of conservative non-pharmacologic (e.g. exercise) and pharmacologic treatments or are intolerant of these therapies. As there is no documentation of failed conservative therapy, the request is not medically necessary.

Associated surgical services: X-rays A/P of the lateral of the right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand, Radiography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

Decision rationale: CA MTUS chapter 11 page 268 recommends wrist x-ray for trauma or direct tenderness over the anatomic snuff box. In this case, the guideline criteria are not satisfied. The request is not medically necessary.