

<b>Case Number:</b>	CM13-0063561		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	08/17/2011
<b>Decision Date:</b>	05/23/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician 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 Physician 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:

This is a 48-year-old female who was injured in a work-related accident on 8/17/11. The specific records for review pertaining to the claimant's bilateral upper extremities documented an operative report dated 3/21/13 noting that the claimant underwent a right thumb carpometacarpal joint arthroplasty and a right carpal tunnel release. A follow up clinical record dated 9/13/13 documented a current diagnosis of left hand pain and continued pain with activity. It was noted at that time that the claimant failed conservative care including multiple injections, bracing, occupational therapy, and the recommendation was made for left carpal tunnel release and carpometacarpal arthroplasty to the left thumb. No imaging studies were provided for review. At present, there is a request for surgical arthroplasty of the thumb with post-operative use of a cryotherapy device and twelve sessions of occupational therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THUMB ARTHROPLASTY:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) -

TREATMENT IN WORKERS COMP, 18TH EDITION, 2013 UPDATES:  
FOREARM/WRIST/HAND PROCEDURE - ARTHROPLASTY, FINGER AND/OR THUMB  
(JOINT REPLACEMENT).

**Decision rationale:** The California MTUS Guidelines are silent. When looking at the Official Disability Guidelines, the request for surgical arthroplasty of the carpometacarpal joint of the thumb would not be recommended. While it is noted that the employee has undergone prior right thumb carpometacarpal arthroplasty, there is currently no documentation of clinical imaging of the left thumb to support advanced degenerative changes. The absence of clinical imaging would fail to satisfy the ODG Guideline criteria for the request for the surgical process in question.

**DURABLE MEDICAL EQUIPMENT (DME): 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 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.

**OCCUPATIONAL THERAPY (OT) - TWO (2) TIMES A WEEK FOR SIX (6) WEEKS TO THE LEFT HAND/THUMB:** 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.