

Case Number:	CM13-0072138		
Date Assigned:	01/08/2014	Date of Injury:	10/25/2010
Decision Date:	07/23/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/30/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/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:

The injured worker is a 40 year old female who reported an injury on 10/25/2010. The mechanism of injury involved repetitive work activity. The current diagnoses include bilateral carpal tunnel syndrome, status post right carpal tunnel release, and bilateral overuse syndrome. The injured worker was evaluated on 11/21/2013 with complaints of persistent left wrist pain. Physical examination revealed positive radial head tenderness bilaterally, diminished grip strength, normal range of motion of bilateral upper extremities, pain with flexion and extension of bilateral wrists, pain with radial and ulnar deviation of the right wrist, positive Tinel's and Phalen's testing bilaterally, diminished motor strength in the finger flexors and hand intrinsic muscles on the right, and increased sensation in the C5 and C6 dermatomes on the left. Treatment recommendations at that time included authorization for a left carpal tunnel release with postoperative durable medical equipment, postoperative physical therapy, preoperative medical clearance, and prescriptions for naproxen 500 mg and Ketoprofen 10% cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

CARPAL TUNNEL RELEASE ON THE LEFT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation DG-TWC Carpal Tunnel Syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: ACOEM 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 modifications, and have clear clinical and special study evidence of a lesion. Carpal tunnel syndrome must be proven by positive findings on clinical examination and supported by nerve conduction tests. As per the documentation submitted, there is no mention of an attempt at conservative treatment for the left wrist. There were also no electrodiagnostic studies provided for this review. Therefore, the injured worker does not meet criteria for the requested procedure. As such, the request is not medically necessary and appropriate.

POST OP PT 3X4: 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.

X-FORCE STIMULATOR 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.

CPM X 14 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.

Q-TECH RECOVERY SYSTEM X 15 DAYS/COLD THERAPY: 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.

PRO 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 BY AN INTERNIST: 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.

NAPROXEN 500MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: The MTUS Chronic Pain Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. As per the documentation submitted, there is no indication that this injured worker is currently suffering from an acute exacerbation of chronic pain. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

KETOPROFEN CREAM 10%: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is Diclofenac. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary and appropriate.

PRE-SURGICAL PHYSICAL THERAPY: 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.