

Case Number:	CM14-0112316		
Date Assigned:	08/01/2014	Date of Injury:	01/12/2011
Decision Date:	09/09/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/18/2014

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, has a subspecialty in Hand 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 46-year-old male who reported an injury on 01/12/2011 due to cumulative trauma while performing normal job duties. The injured worker underwent a magnetic resonance imaging (MRI) of the hand dated 07/21/2013. Findings included a chronic appearing thickening of the ulnar collateral ligament suggestive of a chronic sprain or partial tearing; mild tenosynovitis of the flexor pollicis longus tendon; mild degenerative changes of the 1st carpometacarpal joint and interphalangeal joint of the thumb. The injured worker was evaluated on 04/25/2014. It was documented that the injured worker had persistent right thumb complaints. Physical findings included normal range of motion of the right and left thumb with decreased right-handed grip testing. There was tenderness to palpation along the ulnar collateral ligament. The injured worker's diagnoses included possible rupture of the ulnar collateral ligament on the right. A request was made for surgical repair of the right ulnar collateral ligament. There was no justification provided for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical repair of right ulnar collateral ligament: Overturned

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 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The requested surgical repair of the right ulnar collateral ligament is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for hand injuries are supported by diagnostic evaluation corroborated by clinical examination findings that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker underwent a magnetic resonance imaging (MRI) that identified pathology of the ulnar collateral ligament that would benefit from surgical repair. Although, the clinical documentation does not identify conservative treatments specifically applied to the thumb, this type of injury does not typically respond to physical therapy or immobilization. Therefore, surgical intervention would be appropriate for this clinical situation. As such, the requested surgical repair of the right ulnar collateral ligament is medically necessary and appropriate.

Cold therapy unit 4 week rental: 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), Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested cold therapy unit for a 4-week rental is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend a cold therapy unit to assist with post-surgical pain for up to 7 days. The request exceeds this recommendation. There are not exceptional factors noted to support extending treatment beyond guidelines recommendations. As such, the requested cold therapy unit for a 4-week rental is not medically necessary or appropriate.

Post-operative Physical Therapy 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 21.

Decision rationale: The requested post-operative physical therapy 2 times a week for 4 weeks is not medically necessary or appropriate. The clinical documentation does support that the injured worker is a surgical candidate. California Medical Treatment Utilization Schedule recommends up to 12 post-operative physical therapy visits after collateral ligament repairs of the hand. California Medical Treatment Utilization Schedule also recommends an initial course of therapy of up to half the number or recommended visits to establish efficacy of treatment. This would be equal to six visits. The request exceeds this recommendation. There are no exceptional factors to

support extending treatment beyond guidelines recommendations. As such, the requested post-operative physical therapy 2 times a week for 4 weeks is not medically necessary or appropriate.

Pre-operative medical history and physical laboratory work-up: 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), Low Back Chapter, Pre-Operative Lab Testing (General).

Decision rationale: The requested pre-operative medical history and physic laboratory work-up is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not recommend the routine use of pre-operative lab testing, unless there are co-morbidities that could contribute to intra-operative and post-operative complications. The clinical documentation does not provide any support for the need for pre-operative clearance for this low-risk, ambulatory surgery. As such, the requested pre-operative medical history and physic laboratory work-up is not medically necessary or appropriate.

EKG: 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), Low Back Chapter, Preoperative electrocardiogram (ECG).

Decision rationale: The requested pre-operative EKG is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not recommend the routine use of pre-operative EKGs, unless there are co-morbidities that could contribute to intra-operative and post-operative complications. The clinical documentation does not provide any support for the need for pre-operative clearance for this low-risk, ambulatory surgery. As such, the requested EKG is not medically necessary or appropriate.

Chest X-ray: 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), Low Back Chapter, Pre-operative testing, general.

Decision rationale: The requested pre-operative chest x-ray is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not recommend the routine use of pre-operative chest x-rays, unless there are co-morbidities that could contribute to intra-operative and post-operative complications. The clinical documentation does not provide any support for the need for pre-operative clearance for this low-risk, ambulatory surgery. As such, the requested chest x-ray is not medically necessary or appropriate.