MAXIMUS Federal Services

| Case Number: | CM14-0125772 | | |
|---|---|---|---|
| Date Assigned: | 08/13/2014 | Date of Injury: | 09/03/2013 |
| Decision Date: | 09/23/2014 | UR Denial Date: | 08/05/2014 |
| Priority: | Standard | Application Received: | 08/08/2014 |

## 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 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 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 claimant is a 39-year-old gentleman who was injured in a work related accident on September 3, 2013. The records provided for review document that the claimant sustained a crush injury to the left hand and wrist when his hand was struck on a machine while cutting vegetables. He was initially diagnosed with an intraarticular fracture of the distal radius that was treated with immobilization. The follow up visit on May 14, 2014 noted continued complaints of pain in the wrist. Physical examination was documented to show a positive Phalen's and median nerve compression testing consistent with carpal tunnel syndrome and diffuse tenderness. The medical records do not contain any reports from electrodiagnostic testing of the upper extremity. The recommendation was made for wrist arthroscopy with carpal tunnel release procedure, postoperative physical therapy and use of a functional restoration program.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left wrist surgery, unknown procedure or length of stay:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79. Decision based on Non-MTUS Citation ACOEM guidelines, 2004, 2nd Edition, Chapter 11, page 270.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, 265.

**Decision rationale:** Based on California ACOEM Guidelines, left wrist surgery is not recommended as medically necessary. The medical records document that the physician has recommended a carpal tunnel release but the records do not contain any electrodiagnostic report to confirm the diagnosis of carpal tunnel syndrome. The ACOEM Guidelines recommend that the diagnosis of carpal tunnel syndrome must be proven by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. In addition, the request for left wrist surgery does not identify the surgical procedure/s to be performed. The intended procedure would be necessary before a determination regarding the medical necessity for the surgery can be made.

**Physical therapy 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 99.

**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.

**Start Functional Restoration Program, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program Page(s): 49.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines would not support a functional restoration program. According to the Chronic Pain Guidelines, there appears to be little scientific evidence in the efficacy of multi disciplinarian biopsychological rehabilitative programs. This individual's clinical diagnosis and presentation is still unclear. Therefore, based on the Chronic Pain Guidelines, a functional restoration program for this individual for whom operative intervention is also being recommended would not be indicated.