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| Case Number: | CM14-0156953 | | |
| Date Assigned: | 09/29/2014 | Date of Injury: | 05/04/2012 |
| Decision Date: | 10/27/2014 | UR Denial Date: | 09/10/2014 |
| Priority: | Standard | Application Received: | 09/25/2014 |

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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 patient is a 38 years old female with an injury date on 05/04/2012. Based on the 07/31/2014 hand written progress report provided by [REDACTED], the diagnoses are: 1.S/P right RTC repair 2.Cervical spine sprain and strain- right trap T.P.3.Right elbow, CTS According to this report, the patient complains of neck and right wrist pain. Tenderness is noted over the right trapezius muscle with trigger point and right wrist flexor /extensor muscle. Shoulder depression and Tinel's sign are positive. Decreased sensation of the right 4th finger is noted. There were no other significant findings noted on this report. The utilization review denied the request on 09/10/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 06/12/2014 to 09/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel cortisone injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. 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): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: According to the 07/31/2014 report by [REDACTED] this patient presents with neck and right wrist pain. The treating physician is requesting right carpal tunnel cortisone injection. The utilization review denial letter states "there has been no electrodiagnostic report confirming a diagnosis of right CTS and there has been no evidence that non-invasive conservative treatment recommended by guidelines prior to carpal tunnel injection has been attempted." Regarding cortisone injection, ODG guidelines state "Recommend a single injection as an option in conservative treatment." ODG further states "Carpal tunnel syndrome may be treated initially with a night splint and medications before injection is considered, except in the case of severe CTS." Review of the reports do not show that the patient is diagnosed with a "severe" CTS to warrant a trial of Cortisone injection. Furthermore, the patient has had carpal tunnel release without additional work-up as to why the patient continues to be symptomatic. The request is not medically necessary and appropriate.