

Case Number:	CM14-0217698		
Date Assigned:	02/12/2015	Date of Injury:	10/05/2010
Decision Date:	05/01/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 51-year-old male who reported an injury on 10/05/2010. The mechanism of injury was cumulative trauma. The documentation of 10/27/2014 revealed the injured worker had electrodiagnostic studies of the right upper extremity that were completed. The documentation indicated the injured worker had right upper extremity abnormalities. The injured worker had attended therapy for the right hand and elbow. The documentation indicated the injured worker was utilizing his left upper extremity more and consequently he began experiencing left sided symptoms including pain in the left thumb, index finger, and palmar region. The injured worker was noted to have a course of acupuncture and electrical muscle stimulation. The injured worker attended a course of aquatic therapy, which did not help. The injured worker had subjective complaints of numbness of the right fingers, pain at the base of the right thumb, and pain in several areas of the right forearm. The injured worker had positive pain to palpation in the medial epicondyle. The injured worker had moderate pain to palpation in the ulnar nerve and lateral epicondyle and mobile wad on the right and slight to moderate on the left. The injured worker had positive subluxation and elbow flexion test as well as Tinel's sign in the left and right cubital tunnel. The injured worker had a positive Finkelstein's bilaterally and "Intersxn" test bilaterally. The injured worker had decreased sensation to light touch in the ulnar nerve and median nerve on the right greater than the left. The injured worker had a positive Phalen's sign, Tinel's sign at the carpal tunnel, Tinel's sign at the Guyon's canal and positive ulnar compression test bilaterally in the hands. The injured worker was noted to have electrodiagnostic studies on 03/28/2014. The documentation indicated the injured worker had

failed conservative treatment for De Quervain's disease and for carpal tunnel syndrome. The treatment plan was for surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neuroplasty Median Nerve Carpal Tunnel, Wrist Flexor Tenosynovectomy, Advancement Tissue Rearrangement Hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate that carpal tunnel release is recommended when there are objective findings upon physical examination that are corroborated by neurodiagnostic studies. Additionally, for the treatment of carpal tunnel syndrome there should be documentations of injections of lidocaine and corticosteroids and splinting of the wrist in neutral position. There should be documentation of a failure of conservative care. Additionally, for the treatment of De Quervain's syndrome there must be documentation of pain with limited function, documentation the injured worker has utilized a wrist and thumb splint. The clinical documentation submitted for review indicated the injured worker had failed conservative care including acupuncture, pool therapy and physical therapy. Additionally, there was a lack of documentation of official electrodiagnostic studies to support the need for carpal tunnel release. The request as submitted failed to include the laterality for the requested surgery. Given the above, the request for Neuroplasty median N carpal tunnel, wrist flexor tenosynovectomy, advancement tissue rearrangement hand is not medically necessary.

Neuroplasty Hand, Inj Anesthetic Peripheral Nerve/Br Carpal Tunnel, Incision Extensor Sheath Wrist First Dorsal Comp, Synovectomy Ext Tendon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate that carpal tunnel release is recommended when there are objective findings upon physical examination that are corroborated by neurodiagnostic studies. Additionally, for the treatment of carpal tunnel syndrome there should be documentations of injections of lidocaine and corticosteroids and splinting of the wrist in neutral position. There should be documentation of a failure of conservative care. Additionally, for the treatment of De Quervain's syndrome there must be documentation of pain with limited function, documentation the injured worker has

utilized a wrist and thumb splint. The clinical documentation submitted for review indicated the injured worker had failed conservative care including acupuncture, pool therapy and physical therapy. Additionally, there was a lack of documentation of official electrodiagnostic studies to support the need for carpal tunnel release. The request as submitted failed to include the laterality for the requested surgery. Given the above, the request is not medically necessary.

Neurolysis Dorsal Sens Br Radial N, Inj Anesthetic Peripheral Nerve/Br First Dorsal Comp, Incision Extensor Tendon Sheath Wrist Second Dorsal Comp: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The American College of Occupational and Environmental Medicine indicate that carpal tunnel release is recommended when there are objective findings upon physical examination that are corroborated by neurodiagnostic studies. Additionally, for the treatment of carpal tunnel syndrome there should be documentations of injections of lidocaine and corticosteroids and splinting of the wrist in neutral position. There should be documentation of a failure of conservative care. Additionally, for the treatment of De Quervain's syndrome there must be documentation of pain with limited function, documentation the injured worker has utilized a wrist and thumb splint. The clinical documentation submitted for review indicated the injured worker had failed conservative care including acupuncture, pool therapy and physical therapy. Additionally, there was a lack of documentation of official electrodiagnostic studies to support the need for carpal tunnel release. The request as submitted failed to include the laterality for the requested surgery. Given the above, the request is not medically necessary.

NJ Anesthetic Peripheral Nerve/Br Second Dorsal Comp, Application Short Arm Splint: 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.

Pre-Operative: H & P Single Comp: 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.

Post-Operative Occupational Therapy (3 times a week for 4 weeks): 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.

Post-Operative 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.

Associated Surgical Service: CMP Device (for 30 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.

Associated Surgical Service: DVT Device: Upheld

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

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.

Associated Surgical Service: TENS Device: 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.

Cephalexin 500mg, for 7 days #30: 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.

Ondansetron ODT 4mg, #30 with 1 refill: 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.

Ketorolac (Sprix); Wound Care Cream: 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.