

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0035897 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 05/31/2012 |
| Decision Date: | 01/02/2015 | UR Denial Date: | 03/14/2014 |
| Priority: | Standard | Application Received: | 03/24/2014 |

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:

59-year-old female with reported industrial injury of May 31, 2012. Exam note October 24, 2013 demonstrates the claimant complains of pain and discomfort in bilateral hands with associated numbness. EMG and nerve conduction studies on September 18, 2013 demonstrate mild carpal tunnel syndrome and axonal polyneuropathy. As compared to the September 9, 2011 exam right carpal tunnel syndrome is noted to be worse on the left was not tested previously. Report states the claimant has had a cortisone injection but secondary to concerns regarding diabetes no further injections were recommended. MRI of the left knee dated November 7, 2013 demonstrates articular cartilage fissures on the medial patellar articular surface and bone marrow edema of the subcortical bone of the articular facet. Intra-substance degenerative changes are noted in the medial meniscus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral carpal tunnel release, to the right then left: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Carpal Tunnel Syndrome, Procedure Summary (last updated 02/20/2014)

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

Decision rationale: Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints page 270, Electrodiagnostic testing is required to eval for carpal tunnel and stratify success in carpal tunnel release. In addition, the guidelines recommend splinting and medications as well as a cortisone injection to help facilitate diagnosis. In this case there is lack of evidence in the records from 10/24/13 of failed conservative management. Therefore the determination is for non-certification.

Pre-Surgical Clearance: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

12 Postoperative physical therapy visits of the bilateral wrists/hands, three (3) times per week for four (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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

14 day rental of Surgi-Stim Multi-Modality Stimulator: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

14 day rental of continuous passive motion 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

35 day rental of Q-Tech recovery system: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

15 day rental of continuous 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

30 day rental of X-Force Stimulator (TENS 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Purchase of 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Urine Drug Screen (unspecified date of service): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Pain Chapter, Procedure Summary (last updated 01/07/14), Urine Drug Testing (UDT)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Retrospective magnetic resonance imaging (MRI) of the left shoulder (DOS: 11/07/13):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Procedure (last updated 12/27/13), Magnetic Resonance Imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: According to the CA MTUS/ACOEM guidelines Chapter 9 Shoulder complaints regarding imaging of the shoulder, page 207-208 recommends imaging for red flag symptoms, physiologic evidence of tissue insult or neurovascular dysfunction or failure to progress in a strengthening program. In addition imaging such as MRI would be appropriate for clarification of anatomy prior to an invasive procedure. None of the criteria has been satisfied based upon the records reviewed from 10/24/13. Therefore the request for MRI of the shoulder is not medically necessary and appropriate.

Retrospective magnetic resonance imaging (MRI) of the left knee (DOS: 11/07/13): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Knee and Leg, Procedure Summary (last updated 01/20/14), Magnetic Resonance Imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-345.

Decision rationale: According to the CA MTUS/ACOEM, Knee Complaints Chapter 13, page 341-345 regarding knee MRI, states special studies are not needed to evaluate knee complaints until conservative care has been exhausted. The exam note from 10/24/13 does not demonstrate that a period of conservative care has been performed to meet CA MTUS/ACOEM guideline criteria for the requested imaging. The request for knee MRI is therefore not medically necessary and appropriate.