MAXIMUS Federal Services

Case Number:	CM14-0079191		
Date Assigned:	07/18/2014	Date of Injury:	05/02/2011
Decision Date:	05/08/2015	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/29/2014

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: New York
Certification(s)/Specialty: Anesthesiology

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 43-year-old male who sustained an industrial injury on May 2, 2011. He has reported pain in the right thumb and has been diagnosed with right thumb injury; right thumb localized irregular pain, right thumb IP-1 joint extension contracture with intrinsic tightness, right upper extremity neuritis ulnar nerve, right upper extremity neuritis median nerve, and right thumb and index finger tendinitis A-1 pulley without triggering. Treatment has included physical therapy and injections. Currently the injured worker complains of a burning sensation in the right thumb, throbbing sensation in the right thumb with no relief with cortisone injection. The treatment plan included surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-Operative Medical Clearance/History and Physical: Upheld

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

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

Decision rationale: According to ACOEM Guidelines, medical clearance/history and physical can be provided by the surgeon prior to the procedure. In this case, the patient had no comorbidities that required a separate consultation for preoperative clearance. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Post-Operative Occupational Therapy (12-sessions): Upheld

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

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

Decision rationale: According to ACOEM Guidelines, post-surgical physical medicine treatment frequency is dependent on the type of surgery performed. For extensor tendon repair or tenolysis, there is an allowance of 18 visits over 4 months within the first 6 months after surgery. An initial course of 9 visits is recommended and the remaining 9 would be appropriate if the patient demonstrates functional improvement. Functional improvement is defined as clinically significant benefit with regards to daily activities or work improvement documented during the patient's post-operative evaluations. In this case, the requested 12 sessions of post-operative occupational therapy exceed the guideline recommendations of 9 initial sessions. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Cold Therapy Unit (30-day rental): Upheld

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

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

Decision rationale: According to the CA MTUS/ACOEM Guidelines, the home application of cold packs is just as effective as those performed by a therapist. A cold therapy unit is not supported after tendon repair of the thumb. If cold therapy is desired, cold packs are readily available. There is no specific indication for a 30-day cold therapy unit. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Keflex 500 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse, Institute for Clinical Systems Improvement, Perioperative Protocol, Health Care Protocol, Bloomington (MN).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014, Postoperative antibiotics.

Decision rationale: According to the reviewed guidelines, extending antibiotic prophylaxis beyond 24 hours postoperatively does not decrease the risk of surgical site infection. Prolonged post-operative antibiotics can increase the risk for patient intolerance and complications such as Clostridium difficile colitis. There is no specific indication for the requested Keflex therapy (500mg #30 pills). Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Norco 10/325mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 151. Decision based on Non-MTUS Citation Official Disability Guidelines, Pian (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 10/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, the medication is being used for the treatment of acute post-operative pain. However, the guidelines recommend a limited use of opioids for postoperative pain. The requested amount exceeds the guideline recommendations. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.