

Case Number:	CM15-0009668		
Date Assigned:	01/27/2015	Date of Injury:	10/22/2014
Decision Date:	03/26/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/16/2015

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 59-year-old female who reported an injury due to an unknown mechanism of injury. The injured worker's treatment history had included physical therapy, anti-inflammatory medications, and wrist splinting. The injured worker was evaluated on 01/20/2015. It was documented that the injured worker had undergone an electrodiagnostic study that reported the injured worker had severe carpal tunnel syndrome. Objective findings included a positive Tinel's sign, positive Phalen's test, and positive Finkelstein's test. It was also documented that the injured worker had a median distribution with a 2 point discrimination test of 10 mm. It was also noted that the injured worker had no evidence of carpal tunnel syndrome. The injured worker's diagnoses included cervical spine stenosis and left carpal tunnel syndrome, severe. The clinical documentation submitted for review does provide a nerve conduction velocity study on 11/24/2014 that documented evidence of severe left medial neuropathy indicative of left carpal tunnel syndrome. The injured worker's treatment history included carpal tunnel release for the left wrist. No Request for Authorization was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpel tunnel release for the left wrist: Overturned

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: The requested carpal tunnel release for the left wrist is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for carpal tunnel syndrome for patients who have severe findings of carpal tunnel syndrome supported by an electrodiagnostic study that have failed to respond to conservative treatment. The clinical documentation indicates that this request was previously reviewed and received an adverse determination due to a lack of physical findings to support severe carpal tunnel syndrome. A recent evaluation dated 01/20/2015 does indicate that the injured worker has 10 mm 2 point discrimination with a positive Tinel's and carpal tunnel syndrome. This is supported by an electrodiagnostic study that indicates severe left carpal tunnel syndrome. The injured worker has failed to respond to multiple conservative treatment modalities. Therefore, surgical intervention would be supported in this clinical situation. As such, the requested carpal tunnel release for the left wrist is medically necessary and appropriate.

Post-op Sling: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome Chapter, Immobilization.

Decision rationale: The requested postoperative sling is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not address immobilization following surgical intervention. The Official Disability Guidelines recommend early mobilization following surgical intervention. As such, the requested postoperative sling is not medically necessary or appropriate.

Post-op 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Continuous Cryotherapy Unit

Decision rationale: The requested postoperative cold therapy unit is not medically necessary or appropriate. The Official Disability Guidelines recommend the use of a cold therapy unit for up

to 7 days to assist with postsurgical inflammation and pain. The request as it is submitted does not clearly identify whether the requested unit is for purchase or rental. Additionally, there is no length of need identified. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested postoperative cold therapy unit is not medically necessary or appropriate.

Post op- Pain pump: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Pain Pump.

Decision rationale: The requested postoperative pain pump is not medically necessary or appropriate. The Official Disability Guidelines do not recommend the use of a postoperative pain pump. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Additionally, there is no indication of a length of need for the request. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested postoperative pain pump is not medically necessary or appropriate.