

Case Number:	CM15-0144060		
Date Assigned:	08/05/2015	Date of Injury:	10/27/2011
Decision Date:	09/22/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/24/2015

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: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 63 year old female, who sustained an industrial injury on 10-27-2011, resulting from cumulative trauma. The injured worker was diagnosed as having right de Quervain's disease, right wrist flexor tenosynovitis, right carpal tunnel syndrome, and right ulnar neuropathy Guyon's canal. Treatment to date has included diagnostics, cortisone injections, bracing, interferential unit, ice machine, mental health treatment, and medications. Currently, the injured worker complains of numbness and tingling in the right hand and fingers, discoloration of the right wrist, swelling of the right forearm, pain and numbness in the left ring and little fingers, pain in the right neck and shoulder, pain in the low back, discoloration and coldness in both feet, and difficulty sleeping. Surgical intervention was recommended. The treatment plan included post-operative purchase of a cold therapy device, continuous passive motion device for finger movement, deep vein thrombosis device for the lower extremities, and transcutaneous electrical nerve stimulation device for trial. An operative report was not submitted. A surgical pathology report was submitted (7-08-2015) for the right wrist flexor and extensor synovium.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative DME purchase - Cold Therapy Device, 30 minutes for 3 times per day for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: MTUS recommends low-tech forms of heat or cold in the acute stage of an injury. The treatment guidelines and records do not provide a rationale instead for DME equipment for cold application in the per-operative timeframe. Overall this request is not supported by the guidelines; this treatment is not medically necessary.

CPM Device for Finger Movement x 30 days (rental or purchase not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand / CPM.

Decision rationale: MTUS does not address this issue. ODG recommends CPM specifically after a flexor tendon repair in the hand. It is not clear that such surgery is planned; overall the records contain very limited information and that information is not sufficient to confirm a diagnosis for which this request would be indicated. Therefore the request is not medically necessary.

Purchase a DVT Device to be used for the Right and Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee / Venous Thrombosis.

Decision rationale: MTUS does not address this issue. ODG recommends use of venous thrombosis prophylaxis for subjects at a high risk of developing deep venous thrombosis. The records in this case do not provide a rationale or risk assessment to support an indication for DVT prophylaxis. The request is not medically necessary.

TENS Device, 3-4 times a day in 30 minute intervals for a one month trial, for post surgical to the right wrist/hand, as an outpatient: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain Page(s): 116.

Decision rationale: MTUS recommends TENS as an option for acute post-operative pain within 30 days of surgery. The records document such a plan to utilize TENS in the post-procedure/postoperative setting. This request is medically necessary.