

Case Number:	CM15-0163245		
Date Assigned:	09/08/2015	Date of Injury:	04/03/2013
Decision Date:	10/09/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/19/2015

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, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 sustained an injury on 4-3-13 resulting from a right upper extremity crush injury. Initial diagnoses were acquired musculoskeletal deformity of unspecified site; sprain of carpal of the right wrist; synovitis and tenosynovitis, unspecified; osteoarthritis, localized, primary, forearm. Diagnostic tests include MRI right wrist 5-31-13 and nerve conduction studies. Currently the PR2 from 7-17-15 Orthopedic Hand Surgery Specialist evaluation reports his complaints include increased pain in the right wrist; increased swelling when taking the right wrist brace off for short periods of time; no movement of the right wrist; good movement of the right 4 finger; increasing pain at the base of the right thumb and increasing numbness and tingling electrical dysfunction of the right hand. The examination right wrist was very limited range of motion in all directions; moderate pain with passive range of motion in all directions; moderate to severe pain with attempted palpation of the right wrist; food rotation right forearm; full range of motion right 4 fingers; tenderness right first dorsal compartment. The recommendations included therapy with a certified hand specialist. All conservative management and arthroscopic intervention the chronic pain has worsened and other surgical interventions were listed-partial fusion, total wrist arthroplasty and complete fusion. Current diagnoses include status post right thumb, wrist crush injury; status post right dorsal first web space laceration with primary care closure; status post right wrist, scaphoid fracture (treated with a splint, cast); right chronic wrist pain radiocarpal; right median neuropathy, carpal tunnel; status post right wrist arthroscopy, debridement, synovectomy (4-1-15). Current requested treatments right carpal tunnel release, flexion tenosynovectomy, first dorsal compartment

release, complete wrist fusion; preoperative medical clearance; post-operative occupational therapy, 3 x 4 weeks; post-operative medication: wound care cream compound-Fluticasone 1%, Levocetirizine 2%; Pentoxifyline 0.5%; Prilocaine 3%; Gabapentin 15%, 15 gm, apply 3-4 times per day; post-operative medication: Cephalexin 500 mg #30 no refills, 7 days; post-operative medication: Tylenol #4 #90, 1 every 4-6 hours; post-operative medication: Ondansetron ODT Zofran 4 mg #30 no refills; Associated Surgical Service: 30 day rental of a CPM device for hand and finger movement; Associated Surgical Service: DVT device; Associated Surgical Service: cold pneumatic compression therapy unit, 21-30 day rental or purchase; Associated Surgical Service: Electrical stimulation device; post-operative custom long arm splint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right carpal tunnel release, flexion tenosynovectomy, first dorsal compartment release, complete wrist fusion: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter-Tenosynovitis.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of wrist fusion. ODG hand and wrist is referenced. Wrist fusion is recommended for severe post-traumatic arthritis after 6 months of conservative care. Fusion is recommended as the most reliable especially in young people with anticipated heavy demands. Pain and dysfunction can persist. In this case, severe arthrosis by radiograph is not submitted. The request is not medically necessary.

Post operative medication: Tylenol #4 #90, 1Q4-6 hours: 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Post operative occupational therapy, 3 x 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Post operative medication: Wound care cream compound-Flutacasonone 1%, Levocetirizine 2%, Pentoxifyline 0.5%, Prilocaine 3%, Gabapentin 15%, 150 gram, apply 3-4 times per day: 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Post operative medication: Cephalxin 500mg #30 no refills, 7 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated Surgical Service: 30 day rental of a CPM device for hand and finger movement: 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Post operative medication: Ondansetron ODT Zofran 4mg #30 No refills: 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated Surgical Service: DVT 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated Surgical Service: Cold pneumatic compression therapy unit, 21-30 day rental or purchase: 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Preoperative medical 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. This review presumes that a surgery

is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Associated Surgical Service: Electrical stimulation 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. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Post operative custom long 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.