

<b>Case Number:</b>	CM15-0031929		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	02/13/2014
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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: Maryland, Virginia, North Carolina  
 Certification(s)/Specialty: Plastic 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 43 year old, male patient, who sustained an industrial injury on 02/13/2014. A pain evaluation dated 01/19/2015 reported current subjective complaint of pain and stiffness to neck. The pain is described as constant, throbbing and aching in nature, rated a 6-7 in intensity out of 10. The pain increases with activity, and decreases with medication/rest. He also complains of low back pain that radiates down the left leg. It is described as constant, sharp, throbbing and aching in nature. He is not working at this time. He is prescribed the following medications; Ibuprophen, Flexeril and a topical ointment. Radiographic study performed on 07/08/2014 revealed cervical spine within normal limits and lumbar spine with a 3mm broad based posterior disc protrusion at L4-5 with mild disc desiccation, mild ventral dural compression; mild ligamentum flavum hypertrophy and facet arthropathy. The following diagnoses are applied; cervicalgia; lumbar facet arthropathy; lumbar radiculopathy; and lumbar muscle spasms. A request was made for a left wrist surgery with excision of ganglion cyst; post-operative physical therapy sessions 18-24 treating the left wrist; pre-operative clearance, and testing. On 02/12/2015, Utilization Review, non-certified the request, noting the CA MTUS, surgery, wrist, ODG Low Back Chapter and the ACOEM Chapter 11, pages 270-271 were cited. On 02/20/2015, the injured worker submitted an application for independent medical review of requested services.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left wrist surgery with excision of ganglion cyst:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271.

**Decision rationale:** The patient is a 43 year old male with a symptomatic ganglion cyst diagnosed by MRI and confirmed on examination. From ACOEM, Chapter 11, page 271, 'Only symptomatic wrist ganglia merit or excision, if aspiration fails. Recurrences may be spontaneous or related to inadequate removal of the communication with the carpal joints or to satellite ganglia that the surgeon failed to excise.' There was no documentation of an attempted aspiration/injection or justification for not following this recommendation. Therefore, dorsal ganglion cyst excision should not be considered medically necessary.

**Pre-op clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Preoperative testing, general.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-op physical therapy, 18-24 visits left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-op testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Preoperative lab testing.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.