MAXIMUS Federal Services

Case Number:	CM15-0043687		
Date Assigned:	03/13/2015	Date of Injury:	10/02/2013
Decision Date:	05/12/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/09/2015

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 25-year-old female who reported an injury on 10/02/2013. The mechanism of injury was a fall. Diagnoses included cervical strain, right cervical radiculopathy, right shoulder impingement syndrome, right trigger thumb, right distal radius fracture with positive ulnar variance, right De Quervain's tenosynovitis, bilateral carpal tunnel syndrome, right lateral epicondylitis, right carpal tunnel syndrome, and right cubital tunnel syndrome. Past treatments have included injections to the wrist, bracing, pain medication, and physical therapy. Diagnostic studies included electrodiagnostic studies on 03/19/2014, MRI of the right wrist on 03/20/2014. X-ray of the right wrist on 08/27/2014. Surgical history was noncontributory. The injured worker has complaints of right neck pain with a pressure type sensation on the right side of her face, as well as numbness and blurred vision. She rated her symptoms at an 8/10 with medication and that pain increases to a 10/10 without medication. She has complaints of right elbow pain that she rates at an 8/10 with medication and a 10/10 without medication. She has complaints of right wrist pain radiating into the right hand and fingers that she rates as an 8/10 with medications and a 10/10 without medications. On physical examination of the cervical spine there is decreased sensation over the right C6, C7, and C8 dermatome distribution. There were also a 4+/5 weakness of the left shoulder abductors and trace weakness on the right elbow extension. Examination of the elbows revealed tenderness over the right lateral epicondyle and positive Tinel's over the right cubital tunnel. Examination of the wrist reveals tenderness over the right first dorsal extension compartment, and positive Tinel's and compression test over the right carpal tunnel. There was positive grind test over the first CMC joint. Her medications included

ibuprofen, Zanaflex, Medrol 4 mg dosepak, Ultram. Her treatment plan included a right shoulder injection of Marcaine and Celestone and request for surgery. The rationale for the request was pain relief. The request for authorization form is signed and dated 02/03/2015 in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC) Carpal Tunnel Syndrome Procedure Summary.

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

Decision rationale: The request for carpal tunnel release is not medically necessary. The request does not indicate which side, or bilaterally for the carpal tunnel release. The ACOEM Guidelines indicate that carpal tunnel syndrome must be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. The Official Disability Guidelines further indicate the criteria for carpal tunnel release surgery includes symptoms of Flick sign, nocturnal symptoms, and abnormal CT scan diagram scores. Findings by physical examination would include compression test, Semmes-Weinstein monofilament test, Phalen's test, Tinel's sign, decreased 2 point discrimination, mild thenar weakness. Initial conservative treatment requiring 3 of the following: 1) activity modification of greater than 1 month; 2) night wrist splint of greater than 1 month; 3) nonprescription analgesia; 4) home exercise training; 5) successful outcome from corticosteroid injection trial; 6)positive electrodiagnostic testing. There was a lack of documentation of physical symptoms, and initial conservative treatment including activity modification, night wrist splints, home exercise program, nonprescription analgesia, and corticosteroid injection trial. Therefore, the request for carpal tunnel release is not medically necessary.

Right cubital tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 37. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Elbow Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Surgery for cubital tunnel syndrome (ulnar nerve entrapment).

Decision rationale: The request for right cubital tunnel release is not medically necessary. The Official Disability Guidelines recommendation for surgery for cubital tunnel syndrome indicates initial conservative treatment requires all of the following: exercise, activity modification, medications, and pad/splint. There is a lack of documentation regarding activity modification, padding/splinting. Therefore, the request for right cubital tunnel release is not medically necessary.

Post-op sling purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Campbell's Operative Orthopaedics, 10th ed., Mosby, Inc. pages, 3392 and 3393.

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.

Associated Surgical Service: Assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons.

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-operative medical clearance with chest x-ray: 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) Treatment in Workers Compensation (TWC).

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.

Associated surgical service: Physical Therapy 3x6: 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.

Associated surgical service: Flexion and Extension cervical X-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Neck & Upper Back Procedure Summary.

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.

Associated surgical service: Right hand X-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

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.