

Case Number:	CM15-0056291		
Date Assigned:	04/01/2015	Date of Injury:	07/01/2012
Decision Date:	05/15/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/24/2015

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: New York
Certification(s)/Specialty: Emergency 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 50 year old male who has reported the gradual onset of wrist symptoms attributed to usual work activity, with a listed injury date of 7/1/12. He has been diagnosed with bilateral carpal tunnel syndrome. Treatment to date has included wrist braces, physical therapy, and medications. Per the PR-2 of 2/11/15, there was pain with paresthesias in the hands and wrists. He was currently utilizing Norco and Naproxen daily. Electrodiagnostic testing of the upper extremities showed mild bilateral median neuropathy. Bilateral carpal tunnel releases and a variety of associated services were prescribed. The specific indications for the associated services were not described. The content of the "Home Therapy Kit" was not described. On 2/25/15 Utilization Review certified the carpal tunnel releases, physical therapy, a pre-op evaluation, an EKG, CBC, CMP, PT, PTT, and urinalysis. The cold therapy unit was partially certified. The home therapy kit, wrist brace, chest x-ray, and unspecified "laboratory work-up" were non-certified. The MTUS and the Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit 2 week rental Qty: 2.00: 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), Carpal tunnel syndrome, Continuous cold therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) carpal tunnel syndrome chapter, continuous cold therapy.

Decision rationale: The MTUS does not provide direction for cooling units after surgery. The Official Disability Guidelines recommends them for up to 7 days after surgery. The treating physician prescribed the unit for two weeks, which exceeds the guideline recommendation. The unit is therefore not medically necessary as prescribed.

Laboratory workup Qty: 1.00: 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 (ODG) Low Back chapter, Pre-operative evaluation; Medscape, Drugs and Diseases, review article by Sharma et al, Pre-Operative Testing (available to the public on the Medscape website).

Decision rationale: The request is non-specific and does not identify any specific tests. Presumably this request is related to pre-operative testing, some of which was already certified in Utilization Review. The guidelines cited above recommend pre-operative testing for certain individuals based on specific risk factors. The treating physician has provided no specific indications for any pre-operative testing. Given that the treating physician has not identified any risk factors as indications for testing, and has not identified what is intended by the unspecified laboratory work-up, no unspecified laboratory work-up is medically necessary.

Home therapy unit Qty: 1.00: 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), Forearm, Wrist & Hand, Exercises.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise, Physical Medicine Page(s): 47; 98-99.

Decision rationale: The "Home Therapy Kit" is not described in the physician reports. The treating physician has not discussed the specific indications for this kit or the indications for any components. It is therefore unclear what this kit contains and what its indications, if any, might be. The MTUS makes no recommendation for any particular exercise equipment after initial treatment in formal occupational therapy or physical therapy, with or without any prior surgery. The MTUS for Chronic Pain and the MTUS for post-operative physical medicine recommend

home exercise after supervised physical medicine, with no specific equipment listed. Absent a description of the kit components and their specific medical necessities, an unspecified and generic reference to exercise equipment or some other "kit" is not medically necessary.

Wrist brace for the left hand Qty: 1.00: 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), Forearm, Wrist & Hand, Splinting.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) carpal tunnel syndrome chapter, splinting.

Decision rationale: The MTUS does not address splinting after carpal tunnel release. The Official Disability Guidelines, cited above, notes that splinting after surgery has negative evidence and is not supported by good quality studies. The treating physician has provided no evidence to the contrary. The post-operative splinting is therefore not medically necessary.

Chest x-ray: 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 Medscape, Drugs and Diseases, review article by Sharma et al, Pre-Operative Testing (available to the public on the Medscape website).

Decision rationale: The MTUS does not provide direction for pre-operative evaluations. The other evidence-based treatment guidelines cited above recommend pre-operative testing for certain individuals based on specific risk factors. The treating physician has provided no specific indications for any pre-operative testing. The patient may need no tests, more tests, or this test only, all contingent upon a careful evaluation of current medical status. Given that the treating physician has not identified any risk factors, no chest x-ray study is medically necessary.