

Case Number:	CM15-0057519		
Date Assigned:	04/02/2015	Date of Injury:	06/28/2011
Decision Date:	05/14/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	03/26/2015

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 53-year-old female who reported an injury on 06/28/2011. The mechanism of injury was not provided. There was a Request for Authorization submitted for review dated 03/17/2015. The documentation of 01/29/2015 revealed the injured worker had felt the same since the last office visit and continued to experience pain. The injured worker had marked tenderness at the radial ulnar joint of the right wrist with clicking and catching consistent with a triangular fibrocartilage tear. X-rays of the right hand and wrist were taken which revealed no increase in osteoarthritis. The diagnosis included articular cartilage disorder, pain in joint. The treatment plan included an arthroscopic repair of the triangular fibrocartilage of the wrist. The documentation indicated the injured worker underwent an MRI of the right wrist which revealed a probable triangular fibrocartilage tear. The official MRI dated 10/01/2014 revealed a negative ulnar variant with possible irregularity seen within the triangular fibrocartilage complex, so partial triangular fibrocartilage complex tear could not be excluded. The injured worker was noted to be status post carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dx Opa right wrist repair of TFCT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s):s 270-271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand Chapter, Triangular fibrocartilage complex (TFCC) reconstruction.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that a referral for hand surgery consultation may be indicated for injured workers who have red flags of a serious nature; fail to respond to conservative management, including worksite modifications and who have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The referenced guidelines, however, did not address triangular fibrocartilage complex reconstruction. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that triangular fibrocartilage complex reconstruction is recommended as an option with arthroscopic repair of peripheral tears of the triangular fibrocartilage complex. Conservative care would not be necessary. The injured worker had an MRI, which revealed a possible triangular fibrocartilage tear. The injured worker had clicking and catching in the wrist, which was opined to be consistent with a triangular fibrocartilage tear. However, there was a lack of documentation indicating the injured worker had pain with wrist hyperextension and ulnar deviation and with axial compression pain with forced arm pronation and supination or pain with gripping and ulnar deviation. There was a lack of documentation of a positive piano key sign. Given the above, the request for Dx Opa right wrist repair of TFCC is not medically necessary.

Assistant Surgeon: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative physical therapy, three times weekly for four 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Consult only for medical clearance to include CBC, PT/PTT, UA, EKG and 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 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-operative cold therapy unit, for 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative thirty-day rental of an IF unit: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.