MAXIMUS Federal Services

Case Number:	CM15-0081908		
Date Assigned:	05/01/2015	Date of Injury:	10/27/2003
Decision Date:	06/04/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	04/27/2015

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, Hand 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 67 year old female who reports neck and bilateral upper extremity symptoms attributed to the cumulative effects of occupational activities between 2001 and 2004. Records document extensive evaluation including by multiple independent medical evaluators and extensive treatment including 11 surgeries with right and left carpal tunnel release, elbow epicondylar debridement, right cubital tunnel release, right radial tunnel release, right thumb, long and ring finger trigger release, right shoulder surgery, right first dorsal wrist compartment release and left first dorsal wrist compartment release. An April 15, 2015 report by the treating physician notes decreased cervical spinal motion with pain, trapezial and paracervical tenderness, diminished sensation in the C7 distribution on the right, a positive Spurling's test, equivocal bilateral impingement signs, a slightly tender left volar wrist mass and slight stiffness in the left wrist and hand. The impression is left volar wrist ganglion with FCR tenosynovitis, cervical arthrosis/radiculopathy, trapezial and paracervical strain, bilateral shoulder impingement, right thumb interphalangeal joint arthrosis/mucous cyst, extensor tenosynovitis right long finger, left cubital tunnel syndrome, left radial tunnel syndrome, bilateral forearm tendinitis, left thumb flexor tenosynovitis, status post bilateral deQuervain's releases, status post multiple upper extremity surgeries. The request is for excision left volar wrist ganglion with FCR tenosynovectomy and Menthoderm gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Excision left volar wrist ganglion with FCR tenosynocetomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm Wrist & Hand.

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

Decision rationale: Records document extremely diffuse symptoms of many years duration which have failed to be substantially improved by extensive treatment including many surgeries. The majority of symptoms cannot be attributed to a ganglion cyst or flexor carpi radialis tenosynovitis. There is no documentation of routine non-surgical care for the ganglion. The California MTUS notes on page 271 that only symptomatic ganglia which have failed aspiration warrant consideration of surgical removal. Aspiration has not been performed in this case and the ganglion is not a plausible source of most of the reported symptoms. There is no reasonable expectation that surgical removal of a ganglion would result in substantial functional improvement, such as decreased reliance on prescription medications or return to work. Therefore, the request is determined to be medically unnecessary.

Menthoderm gel 120gm: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The California MTUS notes that topical analgesics are an option for treatment of chronic pain, although the evidence of efficacy is limited and there are no long-term studies. In this case, the records suggest the topical medication requested has been effective for this particular patient and continued use would be low risk. Therefore, the request is consistent with MTUS guidelines and supported by reviewed records and I recommend reversing the decision of the UR reviewer and approving the refill of Menthoderm gel. The request is medically necessary.