

<b>Case Number:</b>	CM15-0084083		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	04/14/2001
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 57 year old male, who sustained an industrial injury on April 14, 2013. He reported neck pain, low back pain, left wrist and shoulder pain. The injured worker was diagnosed as having carpal tunnel syndrome, cervicgia, left shoulder acromion II impingement and tear, left wrist dorsal ganglion on magnetic resonance imaging with pain, cervical foraminal narrowing with radiculopathy to the left arm and wrist and an open wound of the wrist. Treatment to date has included diagnostic studies, radiographic imaging, physical therapy, acupuncture, chiropractic care, medications and work restrictions. Currently, the injured worker complains of neck pain, back pain, bilateral shoulder and upper extremity pain and pain radiating into the lower extremities. He also reported sleep disruptions and a negative impact on the ability to perform activities of daily living secondary to pain. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Magnetic resonance imaging and electrodiagnostic studies in May of 2014, revealed no compressive neuropathy of the bilateral upper extremities. A ganglion cyst of the left wrist was noted. Evaluation on January 29, 2015, revealed continued pain as noted. Evaluation on March 26, 2015, revealed continued constant severe pain. Surgical clearance, surgical removal of the cyst and post-operative physical therapy were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left wrist scope with ganglion cyst/mass excision: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, Chapter 11, Forearm, Wrist and Hand conditions, page 271, ganglion excision is recommended after aspiration has failed to resolve the condition. As the exam notes from 1/29/15 do not demonstrate an attempt at aspiration, the determination is not medically necessary.

**Medical clearance with pre-op labs (CBC/BMP/UA/PR/PTT): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative Lab Testing.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Post operative occupational therapy to left wrist xx4: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.