

Case Number:	CM14-0128851		
Date Assigned:	08/18/2014	Date of Injury:	03/13/2014
Decision Date:	09/19/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/13/2014

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. The expert reviewer is Board Certified in Orthopedic Surgeon, has a subspecialty in Hand Surgeon, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 41-year-old male who reported an injury on 03/13/2014 due to a fall. The injured worker reportedly injured his right wrist. The injured worker initially received an x-ray on 03/24/2014 that concluded there was evidence of a small triquetral avulsion fracture of the dorsal triquetrum. The injured worker underwent a CT scan in 04/2014 that documented a small triquetral avulsion fracture. The injured worker's treatment history included medications, bracing, and 1 physical therapy visit. The injured worker had persistent pain and underwent an MR arthrography on 06/17/2014 that noted evidence of a triangular fibrocartilage disc tear near the ulnar attachment of the triangular fibrocartilage complex. The injured worker was evaluated on 07/25/2014. It was noted that the injured worker complained of continued right wrist pain. Physical findings included decreased range of motion and tenderness to palpation with no evidence of swelling or effusion or crepitus. The injured worker's diagnoses included wrist and forearm pain, and sprain and strain of the radial ulnar joint. The injured worker's treatment plan included resumption of physical therapy. A request was made for a right wrist arthroscopy with postoperative physical care; however, no justification for the request was submitted. Additionally, a Request for Authorization form to support the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Wrist Arthroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation, Online Edition; Chapter: Forearm, Wrist, and Hand; Diagnostic arthroscopy.

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

Decision rationale: The requested right wrist arthroscopy is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends surgical intervention for forearm, wrist, and hand injuries when patients have clear clinical examination findings corroborated by an imaging or electrodiagnostic study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has findings consistent with triangular fibrocartilage complex tear. The clinical documentation does indicate that the patient has not been responsive to physical therapy. Therefore, surgical intervention would be indicated in this clinical situation. However, the request as it is submitted does not specifically identify what type of arthroscopic repair will be provided to the injured worker. Due to the vagueness of the request, the medical appropriateness of the surgery cannot be determined. As such, the requested right wrist arthroscopy is not medically necessary or appropriate.

12 Post- Operative Occupational Therapy Visits: 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: As the primary service is not supported, this associated service is also not supported.