Case Number:	CM15-0117274		
Date Assigned:	06/26/2015	Date of Injury:	06/15/1999
Decision Date:	09/24/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/18/2015

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 56-year-old female, who sustained an industrial injury on June15, 1999. Several documents included in the submitted medical records are difficult to decipher. She reported left wrist pain and swelling, which gradually began in late 1996/1997. The injured worker was diagnosed as having status post left first dorsal compartment release with recurrent/soft tissue; status post left dorsal wrist getting the emphasis excision with recurrent daily advances; and left chronic wrist pain. Diagnostic studies to date have included: On March 5, 2015, an MRI of the left wrist revealed evidence of chronic fracture of the scaphoid and the capitate healed with deformity, severe degenerative disease of the radio scaphoid joints and the intercarpal joints, widening of the scapholunate interval compatible with scapholunate ligament tear, degeneration of the triangular fibrocartilage complex (TFCC), and non-visualization of the extensor tendon of the second digit compatible with complete carrying or previous resection. On March 6, 2015, an electrodiagnostic study of the bilateral upper extremities revealed mild delay of the right median sensory and motor distal latencies with moderate slowing of the right median sensory conduction across the wrist, mild slowing of the left median sensory conduction across the wrist, and mild to moderate left and borderline to mild right carpal tunnel syndrome. On March 19, 2015, a CT scan of the left wrist revealed evidence of contour deformity involving the scaphoid and capitate bones presumably representing sequela of old healed trauma, no evidence of acute fracture or dislocation, diffuse narrowing of all of the intercarpal joint spaces and the radiocarpal joint space with bone on bone contact and possible bony fusion involving the capitate-lunate joint space, subchondral degenerative cystic changes involving the distal radius

and capitate bones, and scapholunate dissociation. Surgeries to date have included: a left carpal tunnel release and cyst excision in 2008/2009. Treatment to date has included preoperative and postoperative physical/occupational therapy; chiropractic therapy; work/activity modifications; a home exercise program; a brace; and medications including pain and non-steroidal anti-inflammatory. There were no noted previous injuries or dates of injury, and no noted comorbidities. Her work status included modified duties: no lifting; no forceful pushing/pulling bilaterally; limited use of the bilateral arm/hand; no repetitive or forceful gripping/grasping bilaterally; no typing, mouse or writing greater than 5 minutes per hour; limited sitting/standing; and no prolonged sitting or driving. On May 1, 2015, the injured worker complains of intense pain of the left wrist and left fingers, difficulty with left wrist movement due to intense pain, occasional left wrist swelling, stiffness of the left fingers, locking of the left thumb and certain fingers, shooting pain from the wrist/hand up to the shoulder, increased pain with left wrist movement, very limited left wrist range of motion, numbness and tingling of all of the left fingers, coldness of the fingers, left hand weakness, and left hand gripping and grasping difficulties. The physical exam of the left wrist and hand revealed cystic masses of the first dorsal compartment and dorsal wrist, very limited range of motion of the left wrist, pain on direct palpation of the cystic masses and the scaphoid and lunate, and positive triangular fibrocartilage complex dorsal/palmer stress load. There was decreased strength and range of motion of the left wrist, normal range of motion and strength of the thumb and fingers, decreased sensation of the ulnar and median nerves. The Jamar dynamometer readings of the right hand were 24/15/22 pounds and of the left hand were 7/7/10 pounds. The treatment plan includes left wrist arthroscopic surgery with immediate postoperative needs: cold pneumatic compression therapy unit; continuous passiv e motion device: finger; deep vein thrombosis device to be use for the right and left lower extremity only; Deep Vein Thrombosis (DVT) Max for home use; an electrical stimulation interferential therapy unit; and Ondansetron ODT (Zofran).

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold pneumatic compression therapy unit, 21 to 30 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand, Continuous Passive Motion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist.

Decision rationale: The definition of DME in the same reference states that the units are typically able to be rented and used by consecutive patients. In this case, the request exceeds the recommended duration. The request is not medically necessary.

Continuous Passive Motion device: finger for thirty days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, wrist and hand, Continuous Passive Motion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist.

Decision rationale: CAMTUS/ACOEM is silent on the issue of continuous passive motion of the wrist. According to ODG wrist, CPM is recommended after flexor tendon repair only. As the request is for a procedure other than flexor tendon repair, the guidelines do not support its use and the request is not medically necessary.

Deep Vein Thrombosis device to be use for the right and left lower extremity only: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Venous Thrombosis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) leg.

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient, there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine knee arthroscopy. Therefore, the request is not medically necessary.

Deep Vein Thrombosis max for home use, purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Venous Thrombosis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) leg.

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient, there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine knee arthroscopy. Therefore, the request is not medically necessary.

Electrical stimulation interferential therapy unit, purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines galvanic stimulation Page(s): 117.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, page 117 and Interferential Current Stimulation, page 118, provide the following discussion regarding the forms of electrical stimulation contained in the SurgStim 4: Galvanic stimulation is not recommended by the guidelines for any indication. In addition, interferential current stimulation is not recommended as an isolated intervention. Therefore, the IFC unit is not recommended by the applicable guidelines and is therefore not medically necessary.

Ondansetron ODT (Zofran) 4mg 1 tablet by mouth once a day pk/30 with one refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, AntiEmetics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, determination is not medically necessary.