

Case Number:	CM15-0162296		
Date Assigned:	09/04/2015	Date of Injury:	03/30/2001
Decision Date:	11/30/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/18/2015

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: Oregon
 Certification(s)/Specialty: Plastic Surgery, Hand 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 53 year old female who sustained an industrial injury on 3-30-01. The injured worker was diagnosed as having trigger thumb release status post release on the right December 2006, carpometacarpal joint inflammation of the thumb bilaterally status post stabilization, left carpal tunnel syndrome, wrist instability on the left status post arthroscopy, wrist instability on the right status post-surgical intervention. Currently, the injured worker reported left thumb pain. Previous treatments included therapy, thumb splints, oral pain medication, transcutaneous electrical nerve stimulation unit, H-wave therapy, heat and ice, muscle relaxants, nonsteroidal anti-inflammatory drugs, and activity modification. Previous diagnostic studies included radiographic studies and a magnetic resonance imaging. The provider noted the injured workers limitations under work status, additionally noting the injured worker stopped working in 2006 and is collecting Workmen Compensation Benefits. The injured workers pain level was not noted. Physical examination was notable for tenderness at the base of the thumb, loss of motion and a weak grip. The plan of care was for Abrasion arthroscopic arthroplasty to base of left thumb quantity of 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Abrasion arthroscopic arthroplasty to base of left thumb QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (updated 6/29/15), Arthroplasty, finger and/or thumb (joint replacement).

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

Decision rationale: According to the ODG guidelines, in our series, total joint arthroplasty of the thumb CMC joint has proven to be efficacious with improved motion, strength, and pain relief for the treatment of stage III and early stage IV osteoarthritis of the CMC joint in older patients with low activity demands. ODG does not provide any support for the treatment of abrasion arthroplasty. The patient had the procedure performed on the opposite thumb and continues to have pain. The CME from 3/2015 indicated that the patient is unlikely to improve with any treatment. Therefore this request is not medically necessary.

Preoperative Medical Clearance including History & Physical QTY 1: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op Labs: CBC: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op Labs: CMP: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: EKG: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op Polar Care 21 day rental: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op Sling QTY 1: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Tramadol ER 150mg QTY 30: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Amox-Clavulanate (Augmentin) 875/125 QTY 40: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Gabapentin (Neurontin) 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per MTUS, Gabapentin is indicated for neuropathic pain. This patient has inflammatory pain and therefore Gabapentin is not medically necessary.

Ondansetron (Zofran) 8mg #20: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Naproxen 550mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: MTUS supports use of non-narcotic analgesics as necessary as an alternative to opioids or to allow for decreased use of narcotics. The patient has nociceptive pain and Naproxen is a recommended treatment. Therefore, the requested Naproxen is medically necessary.

Flexeril 7.5mg #60: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Per the MTUS cited above, co-therapy with an NSAID is not indicated in patients other than those at higher risk. No reports describe the specific risk factors present in this case, as presented in the MTUS. The Protonix is therefore not medically necessary.

Toxicology Urine Drug Screen 10 panel QTY1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004 Guidelines, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: This patient had a diagnosis of chronic pain. The American College of Occupational and Environmental Medicine (ACOEM) in the Occupational Medicine Practice Guidelines on Chronic Pain supports urine drug screens. It is stated on page 156: Recommendation: Urine Drug Screening for Patients Prescribed Opioids for Chronic Pain. Routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician. Indications: All patients on chronic opioids for chronic pain. Therefore this request is medically necessary.