

Case Number:	CM15-0026408		
Date Assigned:	02/18/2015	Date of Injury:	06/24/2014
Decision Date:	04/14/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	02/11/2015

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, 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 46-year-old male who reported an injury on 05/05/2014. The injured worker recalled having struck his right hand while performing his regular job duties. The current diagnoses include right hand/wrist sprain/strain, right hand/ring finger stenosing tenosynovitis, right wrist median neuropathy, and right elbow mild ulnar neuropathy. The injured worker presented on 01/20/2015, for a follow up evaluation. It was noted that the injured worker was initially treated with ice therapy and over the counter medication. The injured worker had also been treated with an injection to the right hand/palm, below the ring finger, for triggering. The injured worker reported persistent pain with activity limitation. There was numbness and tingling of the right thumb, ring, and small fingers noted. Upon examination of the right wrist/hand, there was tenderness to palpation over the volar aspect of the wrist, a positive Phalen's maneuver, decreased sensation to light touch, and normal color and temperature. The injured worker was able to make a composite fist. Recommendations at that time included a right carpal tunnel release. A Request for Authorization form was then submitted on 02/02/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Carpal Tunnel Release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Release Syndrome (Acute & Chronic).

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

Decision rationale: The CA MTUS/ACOEM Practice Guidelines state a referral for hand surgery consultation may be indicated for patients who have red flags of a serious nature, fail to respond to conservative treatment, including work site modification, and have clear clinical and special study evidence of a lesion. Carpal tunnel syndrome must be proven by positive findings on clinical examination and supported by nerve conduction tests. In this case, the injured worker does not appear to meet criteria for the requested procedure. Although it is noted that the injured worker has diminished sensation in the median nerve distribution, a 2 point discrimination test was not documented. It is noted that the injured worker has exhausted conservative treatment. However, there were no electrodiagnostic studies provided for this review. Given the above, the request is not medically appropriate at this time.

Pre operative labs: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cold Therapy Unit, 10 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post operative physical therapy, twice a week for six weeks: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

