

<b>Case Number:</b>	CM15-0026530		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 67-year-old female who reported an injury on 09/19/2011. The mechanism of injury was not stated. The current diagnoses include right wrist joint inflammation, stenosing tenosynovitis along the first extensor compartment on the right, triggering along the thumb on the right, mild carp metacarpal joint inflammation, numbness and tingling along the upper extremities, triggering of the left thumb, internal derangement of the bilateral knees, and chronic pain syndrome. The injured worker presented on 12/16/2014 for a follow-up evaluation. Upon examination, there was tenderness along the medial joint line of the knee with weakness to resisted function. Additionally, there was tenderness along the A1 pulley of the thumb, tenderness along the first extensor, tenderness along the carpal tunnel area, and unremarkable Phalen's maneuver. 2-point discrimination was noted to be intact.

Recommendations at that time included a thumb spica splint, 12 therapy sessions, injection of the A1 pulley of the thumb, a referral to a psychiatrist for depression, a wrist arthroscopy and debridement with carpal tunnel release, and prescriptions for Nalfon 400 mg, Protonix 20 mg, tramadol ER 150 mg, and trazodone 50 mg. A Request for Authorization form was then submitted on 12/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right wrist arthroscopy, debridement and carpal tunnel release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** California 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 management, including worksite modifications; and have clear clinical and special study evidence of a lesion. Carpal tunnel syndrome must be proved by positive findings on clinical examination and supported by nerve conduction tests. In this case, there was no documentation of a significant functional limitation. There is no evidence of carpal tunnel syndrome upon examination. There were no electro diagnostic studies provided for review. As the medical necessity has not been established, the request is not medically appropriate at this time.

**Pre-op clearance history and physical (H&P):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Pre-op complete blood count (CBC):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Pre-op comprehensive metabolic panel (CMP):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Pre-op EKG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Pre-op chest x-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Post-op polar care; 21 day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Post-op sling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.

**Amox-clavulanate 875/125 quantity 20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain 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.