

Case Number:	CM15-0074099		
Date Assigned:	04/24/2015	Date of Injury:	03/02/1999
Decision Date:	06/11/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/17/2015

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: Illinois, California, Texas
 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 73-year-old male who sustained an industrial injury on 3/2/99. Injury occurred when he pulled a stop sign out of the ground and fell back onto his right hand. He was diagnosed with an avulsion fracture and eventually underwent right wrist fusion on 12/29/99. Past surgical history was positive for left wrist proximal row carpectomy and styloidectomy on 9/27/04, left carpal tunnel release with decompression of Guyon's canal on 7/28/05, and left carpal tunnel release with trigger finger releases on 9/28/11. He most recently underwent right cubital tunnel and carpal tunnel release on 7/13/14. The patient had multiple orthopedic issues involving the neck (status post C3-C7 fusion), bilateral shoulders, and both wrists. Records did not document left wrist complaints from 2013 through February 2015. The 3/17/15 orthopedic surgeon report indicated that the right wrist was improved following an injection with no residual pain. He reported that the left wrist had been overused over the past 6 months. The injured worker reported burning discomfort at rest. There was severe central wrist pain with a sharp stinger feeling with grasping and forceful use. Functional difficulty was reported with simple activities. Physical exam documented functional range of motion with no pain in flexion / extension. Ulnar deviation was reported as quite painful with tenderness to dorsal palpation of the capitate. The distal radioulnar joint was not particularly painful. X-rays were obtained and showed advanced cystic deformation of the capitate encompassing 2/3 of the cross sectional area. The orthopedic surgeon opined that this was likely a degenerative geode and would require simple evacuation and bone grafting. He expressed concern for a pathological fracture. Authorization was requested left capitate removal bone cyst and bone graft distal radius

and 8 post-op occupational therapy session Norco 10/325 mg #45 with one refill. The 3/31/15 utilization review non-certified the request for left capitate removal bone cyst and bone graft distal radius and 8 post-op occupational therapy session Norco 10/325 mg #45 with one refill. The rationale for non-certification indicated that there were no diagnostic studies or exam findings to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Capitate Removal Bone Cyst and Bone Graft Distal Radius: Upheld

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

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

Decision rationale: The California MTUS guidelines state that surgical consideration may be indicated for patients who fail to respond to conservative management, and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Guideline criteria have not been met. This patient presents with new onset of left wrist pain and dysfunction secondary to overuse while the right hand was recovering from surgery. There is imaging evidence of advanced cystic deformity of the capitate. However, there is no evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure. In addition, there were limited diagnostic studies and/or comprehensive exam findings to support the medical necessity of this request at this time.

Post-Operative Occupational Therapy (8-sessions): 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.

Norco 10/325mg #45 with 1 refill: 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.

