

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0074754 | | |
| Date Assigned: | 04/24/2015 | Date of Injury: | 05/23/2014 |
| Decision Date: | 06/18/2015 | UR Denial Date: | 04/10/2015 |
| Priority: | Standard | Application Received: | 04/20/2015 |

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 male, who sustained an industrial injury on 5/23/2014. Diagnoses include left hand severe tissue contusion and left wrist triangular fibrocartilage tear with soft tissue contusion. Treatment to date has included diagnostics including magnetic resonance imaging (MRI) (2/04/2015), medications, physical therapy with electrical stimulation, and chiropractic care. Per the Initial Orthopedic Evaluation dated 3/02/2015, the injured worker reported neck, left shoulder and left arm pain. Physical examination revealed tenderness and swelling about eh hand/wrist. He reports pain with motion. There was point tenderness upon palpation of the wrist. There was pain with motion but no instability. There were decreased ranges of motion in all planes of the wrist. The plan of care included additional physical therapy, medications and specialist referral and authorization was requested for a referral to a hand specialist for evaluation of the left wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to hand specialist for evaluation of the left wrist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: The ACOEM Chapter 11 on Forearm, Wrist and Hand indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is rationale provided to support a referral to a hand specialist. Therefore, at this time the requirements for treatment have been met, and medical necessity has been established.