

## Independent Medical Review Final Determination Letter

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Dated: 12/18/2013

<b>IMR Case Number:</b>	CM13-0017670	<b>Date of Injury:</b>	10/30/2012
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	07/30/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	██		
<b>Provider Name:</b>	██		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
Left carpal tunnel release followed by right carpal tunnel release in six weeks, post-operative rehab; three times a week for four weeks with a re- evaluation for continued therapy post visits if needed, and the wrist sling.			

DEAR ██████████,

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

**Final Determination:** Choose an item. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, ██████████  
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## **HOW THE IMR FINAL DETERMINATION WAS MADE**

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in orthopedic surgery, and is licensed to practice in California. 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 physician 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/services.

## **DOCUMENTS REVIEWED**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from (Claims Administrator, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

## **CLINICAL CASE SUMMARY**

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Please provide a one paragraph summary of the relevant clinical issues with a diagnosis or diagnoses relevant to the disputed issue(s). Your summary may be posted on the DWC website for public viewing so please avoid any inflammatory language or disparaging remarks about any aspect of the medical care or claims processes.

The patient is a 51-year-old who was injured on 10/30/12. The patient went to turn a key in a door to open it. The door did not unlock creating a jarring sensation to the hand and an "electrical shock" radiating to his neck and upper back. Since that time, the patient has been with complaints of bilateral upper extremity pain. Electrodiagnostic studies for review from 08/21/13 showed no evidence of cervical or lumbar radiculopathy with findings consistent with peripheral polyneuropathy noted. There was no indication of acute carpal tunnel findings documented. Prior to electrodiagnostic studies, MRI scan of the wrist was performed on 08/15/13 that showed a nonunion fracture at the hook of the hamate, multiple ligamentous injuries including a torn scapholunate ligament chronic in nature, and advanced degenerative arthritis at multiple carpal bones and the radiocarpal joint. The last physical examination for review is from 10/01/13 where there was noted 5/5 motor strength about the bilateral upper extremities, equal and symmetric +2 reflexes, no evidence of muscle wasting with mildly diminished active range of motion of the wrist, tenderness to palpation at the dorsum of the right wrist with no tenderness on the left, negative Phalen's and Tinel's testing bilaterally. At present, there is a request for a left followed by right carpal tunnel release procedure at six week intervals as well as need for 12 postoperative physical therapy sessions and use of a postoperative wrist sling.

## IMR DECISION(S) AND RATIONALE(S)

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

**1. Left carpal tunnel release followed by right carpal tunnel release in six weeks is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11), which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11), page 265, which is part of the MTUS.

The Physician Reviewer's decision rationale: According to the Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines, bilateral carpal tunnel release procedures in a staged fashion are not supported. The employee's electrodiagnostic tests are negative for carpal tunnel findings noting generalized peripheral neuropathy. The employee's imaging also indicates significant degenerative arthrosis, chronic scapholunate tearing and an examination that shows no evidence of carpal tunnel findings with negative Phalen's and Tinel's testing. The role of the surgical process in this case cannot be supported. **The request for left carpal tunnel release followed by right carpal tunnel release in six weeks is not medically necessary and appropriate.**

**2. Post-operative rehab three times per week for four weeks with a re- evaluation for continued therapy post visit, if needed is not medically necessary and appropriate.**

**Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

**3. A wrist sling is not medically necessary and appropriate.**

**Since the primary procedure is not medically necessary, none of the associated services are medically necessary.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

CM13-017670