

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/29/2013
Date of Injury: 6/30/2012
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008516

DEAR [REDACTED],

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: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. 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, [REDACTED]

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 Hand Surgery and is licensed to practice in Texas. 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 the employee's representative
- 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:

The patient is a 53-year-old male who is reported to have developed pain and numbness in the right hand. The patient is noted to have been diagnosed with right carpal tunnel syndrome status post reconstructive surgery of the right shoulder. The patient is noted to complain of pain and numbness in the right hand, which awakened him at night with tingling in the right hand. He reported some improvement in the right wrist and hand following a cortisone injection. The patient was reported to have undergone a nerve conduction study of the right upper extremity. The patient is noted to have been treated conservatively with activity medications, anti-inflammatory medications, narcotic medications and 2 cortisone injections to the right wrist with temporary relief of symptoms, and then they reoccurred. He is reported to have undergone a nerve conduction study which is reported to show borderline carpal tunnel syndrome. The patient is noted on physical exam to have positive findings of carpal tunnel with a positive Tinel's at the left and right wrist, positive Phalen's sign at the left and right wrist, and positive compression sign at the left and right wrist. Sensation was intact in all digits and there was no evidence of thenar weakness or atrophy or interosseous weakness.

IMR DECISION(S) AND RATIONALE(S)

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

1. Right endoscopic carpal tunnel release is not medically necessary and appropriate.

The Claims Administrator based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Table 11-7, which is part of MTUS.

The Physician Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), pgs. 270-271, which is part of MTUS.

The Physician Reviewer's decision rationale:

The employee is a 53-year-old who reported an injury to the right upper extremity. The medical records provided for review indicate that employee is noted to complain of pain and numbness in the right hand which awakens the employee at night. The employee is reported to also complain of tingling of the hand and to have undergone cortisone injections, which were reported to have provided temporary relief of symptoms. The employee is noted on physical exam to have positive Phalen's, Tinel's and compression sign. The employee is reported to have undergone a nerve conduction study of the right upper extremity on unstated date which is reported to show borderline carpal tunnel syndrome. The MTUS/ACOEM guidelines recommend a carpal tunnel release for carpal tunnel syndrome when there are positive findings on clinical exam and the diagnosis is supported by nerve conduction test before surgery is undertaken. Although the employee is reported to have positive findings on physical exam and is reported to have undergone the nerve conduction study that is reported to show findings of carpal tunnel syndrome, the nerve conduction study itself is not available for review and as such the requested right carpal tunnel release does not meet guidelines' recommendations. **The request for Right endoscopic carpal tunnel release is not medically necessary and appropriate.**

2. Pre-Operative laboratory test is not medically necessary and appropriate.

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

3. Pre-Operative Electrocardiogram is not medically necessary and appropriate.

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

4. 12 Post-Operative physical therapy visits is not medically necessary and appropriate.

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

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CM13-0008516