

<b>Case Number:</b>	CM14-0100741		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	08/13/2010
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Mississippi. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records presented for review, indicate that this 46- year-old individual was reportedly injured on August 13, 2010. The mechanism of injury was noted as a lifting type event. The most recent progress note dated May 12, 2014, indicated that there were ongoing complaints of right wrist pain. The physical examination demonstrated a normal range of motion, surgical scars, and tenderness to palpation. Diagnostic imaging studies objectified ordinary disease of life ganglion cyst type changes. Previous treatment included surgical intervention, multiple medications and pain management techniques. A request had been made for surgical treatment and was not certified in the pre-authorization process on June 3, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right dorsal wrist ganglion cyst excision with reconstruction of the right dorsal wrist wound.:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist/hand chapter, updated August 2014.

**Decision rationale:** The request is to excise a dorsal ganglion cyst. However, the progress note indicated the MRI report identifying degenerative osteoarthritis, a subchondral cyst, a slight tear of the proposed fibers of the triangular fibrocartilage. There was a no narrative in the MRI that objectified the presence of a ganglion cyst. Additionally, as outlined in the treatment planning parameters noted in the ODG (MTUS and ACOEM do not address), there is no discussion as to what conservative measures have been undertaken to address this "ganglion cyst." Therefore, based on the narrative presented there is insufficient evidence to support the medical necessity to excise a ganglion cyst. Therefore, the request is not medically necessary.

**Post op OT 3 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist/hand chapter updated August, 2014.

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

**Post op custom fabricated splint:** Upheld

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

**CPM for the finger 30 days.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand Chapter, Continuous Passive motion.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand chapter updated August, 2014.

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

**Cold therapy unit 30 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic) - Continuous Flow Cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand chapter updated August, 2014.

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

**Keflex #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/21975095>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:national institution of health guidelines, accessed on 8/26/14.

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

**Norco #90 with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

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

**Zofran #30 with one refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Antiemetics for opioid nausea.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter updated August, 2014.

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