

<b>Case Number:</b>	CM14-0156473		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	11/18/2005
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 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 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 claimant is a 55-year-old gentleman who was injured on 11/18/05. The clinical records provided for review included the 08/18/14 progress report noting the claimant's complaints of right wrist pain and swelling. The records also documented that the claimant was diagnosed with a dorsal ganglion cyst. Physical examination showed evidence of a cyst, positive Tinel's and Phalen's testing, and no neurologic findings. There was no documentation of specific treatment in regard to the claimant's ganglion cyst; specifically no documentation of prior aspiration attempts. Based on the claimant's current clinical presentation, the recommendation was made for a ganglion cyst excision, synovectomy, and capsular repair. There are also postoperative requests to include the use of a splint, perioperative injection, preoperative history and physical examination, postoperative physical therapy, cryotherapy use, CPM device, and medications to include Norco, Keflex, and Zofran.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Excision of a Ganglion Dorsal Cyst: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Chapter, Surgery for Ganglion Cysts.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** Based on California ACOEM Guidelines, the request for surgical excision of the ganglion cyst cannot be recommended as medically necessary. The ACOEM Guidelines with regard to ganglion cyst removal recommend surgery for only symptomatic ganglia that have failed aspiration require excision. Presently, there is no documentation within the records for review of a prior aspiration attempt for the claimant. Without documentation of conservative care including previous aspiration attempts, the request for surgical excision of the ganglion cyst would not be supported.

**Synovectomy, Extensor, Wrist, Single:** 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.

**Capsulorrhaphy/Recon Wrist Repair:** 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.

**Application Short Arm Splint:** 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.

**Injection of Anesthetic for the Peripheral Nerve:** 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.

**Pre-Operative H&P (History & Physical): 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.

**Post-Operative Occupational Therapy three times per week for four weeks (3x4): 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.

**Cold Therapy for thirty (30) days: 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.

**CPM Device for finger movement for thirty (30) days: 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.

**Keflex 500mg #30: 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 #90 with One (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.

**Zofran 4mg #30 with One (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.