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| <b>Case Number:</b>   | CM14-0218928 |                              |            |
| <b>Date Assigned:</b> | 01/09/2015   | <b>Date of Injury:</b>       | 09/08/2009 |
| <b>Decision Date:</b> | 03/16/2015   | <b>UR Denial Date:</b>       | 12/11/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/30/2014 |

### 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. 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: California

Certification(s)/Specialty: Orthopedic Surgery

### 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 patient is a 42 year old male who sustained a repetitive work related injury to his bilateral wrists, hands and left middle finger while employed as a security guard on September 8, 2009. The injured worker was diagnosed with bilateral cubital tunnel syndrome, bilateral carpal tunnel syndrome and left middle trigger finger. The physician's progress note dated July 30, 2014 documents prior multiple trigger finger releases and right ganglion cyst excision. The patient continues to experience bilateral hand numbness and tingling, bilateral elbow pain, and locked left middle finger. According to the electrodiagnostic test on October 24, 2104 there was evidence of ulnar neuropathies at both elbows. There was no evidence of carpal tunnel syndrome or a generalized peripheral neuropathy affecting either upper extremity. According to the primary treating physician's progress report on November 26, 2014 there is locking and triggering of the left ring finger in flexion and a positive Tinel's at the cubital tunnel bilaterally. The patient is awaiting surgery for a left ulnar nerve decompression. Current medications consist of Cyclobenzaprine, Vicodin, Tramadol, and Terocin lotion. The injured worker is Permanent and Stationary (P&S).The treating physician requested authorization for a post-op splint purchase for the left finger.On December 11, 2014 the Utilization Review denied certification for the post-op splint purchase for the left finger since there is no surgical intervention requested for the trigger finger.Citation used in the decision process was the Official Disability Guidelines (ODG) Forearm, Wrist & Hand.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-Op Purchase Splint for The Left Finger: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Forearm, Wrist and Hand, Splints

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of splinting for the finger. According to ODG, Forearm, Wrist and Hand, Splints, "Recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting. Treating fractures of the distal radius with casting versus splinting has no clinical difference in outcome. See also Casting versus splints. Mallet finger: treatment commonly involves splinting of the finger for six or more weeks. Splints used for prolonged immobilization should be robust enough for everyday use, and of the central importance of patient adherence to instructions for splint use." In this case the exam notes from 11/26/14 do not demonstrate a medical need satisfying the guidelines for a splint. Therefore the determination is for non-certification.